

HEALTH MANAGEMENT ASSOCIATES

HMA COMMUNITY STRATEGIES

Evaluating the Effectiveness of Los Angeles County's Strategies to Expand and Enhance Interim Housing and Emergency Shelter Services

Draft Report

PREPARED FOR
CHIEF EXECUTIVE OFFICE, LOS ANGELES COUNTY

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We would also like to thank all the county agencies and direct service providers who are working tirelessly to address homelessness.

Executive Summary

Background

In 2016, the Los Angeles County Board of Supervisors approved 47 coordinated strategies to combat homelessness, which were developed under the leadership of the Office of the Homeless Initiative (HI) established in the County's Chief Executive Office (CEO) in August 2015. Measure H, approved by the Los Angeles County (LA County) electorate in March 2017, generates an estimated \$355 million in annual funding for 10 years for the HI with the goal of connecting 45,000 individuals and families to permanent housing in five years and preventing homelessness for 30,000 more.¹

In 2018, the Los Angeles Homeless Services Authority (LAHSA) Point-In-Time (PIT) count reported its first decrease in the PIT homeless population in four years, with 52,765 individuals and family members experiencing homelessness.² Between the 2018 and 2019 PIT counts, LAHSA reported preventing and ending homelessness for more people in LA County than ever before: 5,643 people were prevented from entering homelessness, 21,631 people were placed in homes, and 27,080 experienced other exits to housing. However, as documented by the 2019 PIT count, homelessness increased by 12% to 58,936 individuals in 2019. LA County continues to struggle with a large homeless population, roughly three-quarters of which, according to the 2019 PIT count, is unsheltered, with approximately 11,000 people living in tents or encampments and approximately 16,000 people living in cars, vans, or RVs/campers.

Purpose

The purpose of evaluating the HI's interim housing strategies is to produce information that will facilitate these strategies in meeting their underlying objective to expand and enhance interim/bridge housing for those exiting institutions (Strategy B7) and enhance the emergency shelter system (Strategy E8), to determine best practices and areas in need of improvement, and to clarify how persons working directly with the homeless population define and understand program effectiveness and the degree to which this understanding is consistent with performance data. Additionally, this report examines differences in administration of various homelessness services funding sources and their impact on service provision.

Evaluation Objectives and Research Questions

Objectives

In procuring this HI strategy evaluation, as well as four others, the CEO specified four overall objectives to be addressed in the analyses:

Objective 1. To establish what the available data and performance evaluation results suggest are the strategy's best practices and to identify practices and processes in need of being re-visited and re-worked.

Objective 2: To reveal how persons working directly with the homeless population in the strategy define effectiveness and characterize the practices that the data suggest either bolster or impede strategy

¹ <https://homeless.lacounty.gov/about/>

² The PIT count reflects number of people who meet the HUD standard for homelessness on a typical night in Los Angeles County.

performance. Are their characterizations consistent with what the data show? If not, how do they understand the divergence?

Objective 3: To describe how specific funding sources affect the administration of a strategy and the capacity of strategy leads to deploy available resources effectively. To the extent that funding source restrictions create challenges in optimizing available resources, what are they and are there steps that can be taken to minimize them?

Objective 4: To detail instances in which strategy leads provide both services with Measure H funds and similar services not funded with these revenues. How does the administration of non-H-funded services and benefits differ from the administration of those funded with H dollars? What are the practical implications of this difference? Does the difference suggest non-H-funded homeless services would benefit from adopting practices specific to the H-funded portion of the same services and/or vice versa? How much does the answer to this question depend on the non-H funding sources and restrictions involved?

Additional Research Questions

In addition, specific research questions to evaluate Strategies B7 and E8 include:

Research Question 1: How do the Department of Health Services (DHS), the Department of Public Health (DPH)/Substance Abuse Prevention and Control (SAPC), and the Los Angeles Homeless Services Authority (LAHSA) B7 services differ in practice?

Research Question 2: How do bed rates affect interim housing shelter operations and outcomes?

Research Question 3: How does the provision of interim housing services differ by subpopulation and what are the challenges encountered in serving different groups? What are the operational challenges associated with the following types of services falling under strategies B7 and E8: DHS – Medical Recuperative, Psychiatric-Recuperative, Stabilization, DPH-SAPC Beds; LAHSA – Crisis, Bridge, Women’s, Transitional Housing for Domestic Violence Survivors?

Research Question 4: What is the quality of collaboration with the Department of Mental Health (DMH), Department of Children and Family Services (DCFS), Los Angeles County Sheriff’s Department (LASD), and Probation? What do each of these agencies do to support interim housing efforts and what is the significance and impact? Can coordination be improved or enhanced, and if so, how?

Research Question 5: What is the process and what challenges do hospitals face securing housing through B7 for inpatients/clients as required by the SB-1152 Hospital Patient Discharge Process? What is the potential role for Recuperative Care services for enhancing linkages from hospitals to interim housing?

Research Question 6: What is the potential for interim shelters to implement recovery-oriented principles into their environment and service delivery and how might that impact overall integration of services across sectors? (An example of recovery-orientation implementation is use of a person-centered assessment and planning process that incorporates the strengths and goals of individuals served and case management to support effective transition between treatment and service sites).

Research Question 7: What are the most difficult barriers to making transitions from interim housing to permanent housing?

Research Question 8: What are the differences among subpopulations (e.g., various sociodemographic groups, baseline substance use and mental health conditions) in outcomes including return to homelessness, permanent housing, and length of stay (LOS) in interim housing?

Methods and Data Sources

HMA used a mixed methods approach for this evaluation. The primary objectives and research questions address program process and implementation, and most of the methods were qualitative in nature, specifically document review and in-depth interviews with program staff from LAHSA, DHS, DMH and other organizations contracted to provide interim housing services.

Data were collected through 25 key informant interviews conducted with County agency staff, shelter provider staff, and hospital staff from July through October 2019. We also reviewed program documentation including the LA County Homeless Initiative Quarterly Reports. For the quantitative components of this report, CEO made de-identified client-level data available to us from the Homeless Management Information System (HMIS) and from DHS's CHAMP system. Aggregate data on number of individuals served by DMH and SAPC were also shared with us by CEO for illustrative purposes.

Data Analysis

For qualitative data, detailed notes taken during each interview were examined using specialized qualitative data methods. Interviews were also recorded as back-up and confirmation of notes. Codes were developed to reflect each research question and analysis was conducted by question, with key themes identified, and illustrative examples highlighted.

HMIS Data Sample

The HMIS sample constructed for this analysis included adult heads of household enrolled in either emergency or transitional housing, with entry date on or after July 1, 2017, and with valid exit date following July 1, 2017. (See Appendix D for details on sample selection.) HMIS data primarily track persons receiving interim housing services through LAHSA, with relatively little overlap with services provided through DHS (described below). The total sample size for analysis was 20,574 adults.

Demographic variables were defined as per the "HMISSCVSpecifications6_11" data dictionary. Analysis included bivariate comparisons in mean differences (using one-way ANOVA for multiple group comparison) and categorical differences (using chi-square) in exit to permanent housing, length of stay (LOS), and exit to homelessness, among the following subpopulations: ethnicity, race, gender, veteran status, domestic violence, substance abuse problem, mental health problem, and Coordinated Entry System (CES) score, which uses the Vulnerability Index-Service Prioritization Decision-Assistance Tool to assign a score to determine the best type of permanent housing solution.

CHAMP Data Sample

The DHS/CHAMP sample constructed for this analysis included all unique individual cases included in the Interim Housing datafile with check-in date on or after July 1, 2017, and a valid check-out date. All de-

duplicated records were included in the analysis sample. The total sample size for analysis was 3,489 persons. CHAMP data track persons receiving recuperative and stabilization housing services predominantly through DHS.

Analysis included bivariate comparisons in mean differences (using one-way ANOVA for multiple group comparison) and categorical differences (using chi-square) in exit to permanent housing and length of stay among the following subpopulations: ethnicity, race, gender, veteran status, and housing type.

Summary of Results

Differences in interim housing services among agencies

Interim housing service provision among agencies is differentiated by the populations targeted, specifically their physical and behavioral health needs. DHS, for example, primarily provides recuperative care and stabilization housing for individuals requiring assistance with physical ailments, while LAHSA provides shelter services for persons not needing assistance with physical ailments and/or daily living. In practice, services provided are similar, including intensive case management with the goal of moving individuals to permanent housing.

Bed Rates

Providers expressed appreciation that bed rates have increased since the inception of Measure H. However, bed rates, currently reported from \$44 to \$135 per night depending on housing type, were considered too low by providers and other key stakeholders. Providers recommended a rate increase for both interim and recuperative care housing. Shelters experience operational challenges during non-traditional hours and increased bed rates would allow for hiring of licensed staff to be on site after hours. Additionally, because most clients have a number of complex needs, higher bed rates would allow an expansion of services, such as workforce development, enhanced case management, and on-site health and mental health services. Key stakeholders did not necessarily speak to the tension between higher bed rates and the possible reduction in persons served that would result, although we discuss this below in the Recommendations section.

Differences in services among subpopulations

Shelter providers discussed challenges in serving specific sub-populations, including LGBTQ, transition-aged youth (TAY) and domestic violence survivors. Those serving TAY expressed a need for more services that are TAY-specific, including employment support, family/parenting support and financial literacy. Those serving LGBTQ individuals (including TAY) expressed a need for more clinical mental health services. Domestic violence victims require services such as trauma-informed care. Some standard practices such as diversion as a first-line strategy for domestic violence victims are inappropriate, given victims often share friends and family with their abusers, and they cannot rely on their own social network for safety. Those serving immigrant, monolingual, and Limited English Proficient clients expressed challenges with a lack of culturally appropriate services, particularly in the Asian/Pacific Islander communities.

Collaboration among County agencies and providers

The regular, ongoing, and highly collaborative interaction among key agencies, including DHS, LAHSA, DMH, and the HI, resulting from Measure H, is one of the key strengths of the program. A key indicator

of successful collaboration is the development of shelter standards of care that were implemented by DHS, LAHSA, and DMH in September 2019. Prior to Measure H, consistent standards across shelter types and agencies did not exist. The sheer increase of beds as a result of Measure H prompted the recognition that standards were crucial to consistent and high-quality service provision

Process and challenges for hospitals

County hospitals have well-established referral pathways to DHS for Recuperative Care/Stabilization Housing, with DHS-funded staff on site who, along with certain hospital staff working with the homeless population in emergency departments, have direct access to the DHS CHAMP data system. However, some private hospitals are located in areas without many recuperative care providers. This was specifically mentioned for Service Planning Area (SPA) 6. Both types of hospitals have focused efforts on identifying and referring homeless individuals. There is great opportunity to link individuals to interim housing through Recuperative Care, though challenges with long wait times, particularly for private hospitals, remain an obstacle.

Potential to implement recovery-oriented principles

The expansion of interim housing beds due to the infusion of Measure H funding gives shelter providers significant potential to incorporate recovery-oriented principles such as a person-centered and strengths-based approaches into their programs. Most of the shelters are already applying a Housing First approach and focusing on harm reduction in addition to recovery support. Providers have received training from LAHSA in trauma-informed care models, which can be further strengthened through LAHSA's Learning Collaborative and sharing of best practices.

Challenges transitioning to permanent housing

The number one barrier to transitioning to permanent housing that key informants identified is the lack of permanent housing capacity in the County. Another commonly mentioned set of barriers stems from difficulties faced by clients with high mental health and/or substance use acuity levels in living independently.

Subpopulation differences in outcomes

Significant differences were observed in the demographics and health status profiles of those examined for this evaluation in the duration of their stays in interim housing, in exiting to permanent housing (PH), and in exiting to homelessness. In both the HMIS sample (persons receiving predominantly LAHSA-funded interim housing services) and CHAMP sample (persons receiving recuperative care and stabilization housing through DHS), whites (23%) were the least likely to exit to permanent housing among racial groups, and females (29% of HMIS sample and 26% of CHAMP sample) were more likely than males (26% of HMIS sample and 23% of CHAMP sample) to exit to permanent housing. In the HMIS sample, veterans were more likely to exit to PH than non-veterans (34% versus 23%).

Additional subpopulation differences among those with substance use problems, mental health problems, and those with high versus lower CES scores were found in all three outcomes. Those flagged in HMIS with substance abuse problems were less likely than those with no substance use problems to exit to permanent housing and more likely to exit interim housing to homelessness. Those flagged with a mental health problem had a longer length of stay (LOS) than those without a mental health problem, and, similar

to those with a substance abuse problem, were more likely to exit to homelessness. Looking at combined mental health and substance abuse problems, those with a substance abuse problem only and those with co-occurring substance abuse and mental health problems were the least likely to exit to permanent housing, and those with co-occurring problems were most likely to exit to homelessness.

A somewhat different pattern was found for CES acuity score (which is based on a wide range of factors including substance abuse problems, mental health problems, history of homelessness, risk of harm, history of trauma, and other social functioning indicators). Those in the highest acuity category (score of 8+) were more likely than those in the less acute categories (0-3 or 4-7) to exit to permanent housing; however, this same group was also the most likely to exit to homelessness.

Best practices and processes in need of improvement

Several best practices were identified as a result of this evaluation. These include:

- The overall increase in interim beds is a significant accomplishment, as are the increased outreach and strong referral processes, which have resulted in improved access to shelters.
- The referral process from County DHS hospitals to Recuperative Care is seamless and efficient.
- Several “low barrier” strategies including 24-hour shelters, harm reduction policies for those with SUDs, accommodations for pets, and storage for belongings were all identified as best practices in terms of increased access to interim housing.

Additionally, several processes and areas needing improvement were identified, including:

- Lack of continuity of care—i.e., continuation of services provided by a consistent staff/counselor across housing venues—is a key area in need of improvement. Maintaining relationships with clients is critical to the support provider staff can provide in helping clients transition through levels of interim housing towards the goal of permanent housing.
- The referral process, access to CES in private hospitals, and lack of recuperative care providers in some SPAs is a significant challenge to identifying appropriate housing upon hospital release.

Definition of program effectiveness

Most key informants interviewed for this evaluation recognize that the most important objective of interim housing is to move individuals to permanent housing. Multiple data sources, including both quantitative performance metrics and qualitative data in case files, are reviewed regularly to assess program effectiveness and identify programmatic issues with respect to transitions to PH.

Funding Sources, Restrictions, and Administration: Effects on service provision in practice

Multiple funding sources have different eligibility requirements, certification requirements for staff, performance targets, reporting requirements, and bed rates, which is a significant challenge for program administration. While acknowledging the challenges incurred with multiple funding sources, shelters provide the same level of services for all clients. Respondents described complicated funding policies at the administrative level to ensure consistent services. More streamlined funding processes and requirements would be beneficial and would result in significant reduction of administrative burden.

Recommendations

Based on our evaluation, we have identified a set of recommendations for enhancing the ongoing work for Strategies B7 and E8. These recommendations are based on input from key informants as well as HMA's assessment of key areas of focus. Key recommendations include the following:

Services

Key informants interviewed for this evaluation suggested enhancing service provision in multiple areas. However, given funding limitations of Measure H, any increase in services in one strategy or service area would likely result in a decrease in funding for other strategies/services. Given the centrality of the interim shelter strategies to the County's overall coordinated approach to homelessness—a degree of importance that is further amplified by current permanent housing shortages the County should seek to identify or generate additional resources for key services to be made available through or in coordination with interim housing providers, including the following:

- Employment services can be provided at shelter sites and focused on employment opportunities that offer a living wage and increase self-sufficiency. Providing incentives for employment services providers could increase their commitment to working with the homeless population.
- Community-based clinical and physical health services can be made available to better meet the needs of high acuity persons in the interim housing system. This is particularly the case for clients in need of SUD treatment services, which are lacking at shelter sites.
- Increase the allowable LOS at shelters, especially for high-acuity clients. Measure H has resulted in increased services for those exiting institutions, and this has increased the number of complex, high-acuity clients entering the interim shelter system. The challenge at this level is to set shelter stay durations in a way that extends stays for certain groups using these services but also minimizes bottlenecks in moving new clients from the street to shelters. While finding the right balance could be difficult, longer LOS will help maximize the likelihood of successful transitions from interim to permanent housing.

Staffing

- While shelter providers have successfully scaled up since Measure H was implemented, it is important to ensure they have the support and resources needed to continue to grow and expand.
- Target funding to provide intake, counseling, and case management staff during the evening hours and hire problem-solving specialists.
- Assess salary rates for staff based on experience needed to work with acute populations. If funding is not available to hire more experienced staff, alternative staffing models, such as regional professionals who rotate sites, should be explored.

Referral/Intake Process

- Develop a process that will allow real-time assessment of all open beds, particularly in emergency shelters. Streamline communication between interim housing and emergency shelters so that immediate and direct referral to emergency housing can be made in the event individuals show up to interim housing sites without bed availability.

- Examine strategies to increase the accuracy of initial assessments. This may include re-examining and revising the assessment instrument. Often clients may not adequately comprehend the questions in the CES intake survey, resulting in inaccurate scoring. Provide additional training to CES and other intake staff on interfacing with clients to determine acuity levels during the intake process.
- The referral process from private hospitals to both DHS and the CES should be strengthened. Provision of CES staff on site at hospitals (potentially funded by the hospitals themselves) could make the referral process faster and more efficient.

Continuity of Care

- Develop protocols to allow the same case manager to work with clients throughout the continuum — from interim to permanent housing — to support clients for at least a 3-month period after placement in permanent housing. This will alleviate the need for permanent housing staff to devote time to developing trust with clients and increase the likelihood of successful stays in permanent housing. This could be accomplished through interdisciplinary teams, like what occurs in Strategy E6.

Collaboration

- Enhance collaboration with and participation by SAPC. Other departments are working collaboratively, but service provision could be improved with more intensive involvement of SAPC staff, both at the leadership level and the shelter provider level.³
- Build on the successful collaborative effort to develop shelter standards to move toward more consistent standards across departments in other areas, including contract requirements, performance metrics, and reporting requirements, particularly across DHS, LAHSA, and DMH. Continue to explore other areas to streamline forms and processes required by various agencies.

Bed Rates

- Explore ways to increase bed rates above the current rates for interim beds, and recuperative care/stabilization housing beds. The higher rates will allow for additional services, more experienced staff, and can ultimately shorten the LOS with more intensive services in a shorter period of time.

Funding Sources

- Identify ways to streamline the processes and requirements of multiple funding sources. For example, new state money allows alignment with Measure H, and this funding source can be administered with requirements that are consistent with LAHSA requirements.

³HMA made multiple attempts to contact and interview SAPC staff but were unable to do so. Thus, findings related to SAPC services and perspectives on Measure H interim and emergency housing are lacking for this evaluation.

Background

In 2016, the Los Angeles County Board of Supervisors approved 47 coordinated strategies to combat homelessness after extensive community input including stakeholder focus groups and interviews (See Appendix A: “Approved Strategies to Combat Homelessness”). The process was led by Phil Ansell, director of the County’s Homeless Initiative (HI), and engaged community-based organizations, city and county department leads, philanthropy, and most importantly, individuals who have experienced homelessness. The full action plan now includes 53 interconnected strategies developed by more than 100 community groups, 30 cities, and key county leadership.

Measure H, approved by Los Angeles County (LA County) voters in March 2017, generates \$355 million in annual funding for 10 years for the Los Angeles County Homeless Initiative over ten years, with the goal of connecting 45,000 individuals and families with permanent housing in five years and preventing homelessness for 30,000 more.⁴ Measure H is funding a variety of social services, mental health services, addiction treatment, outreach, and enhanced supportive services⁵.

In 2018, the Los Angeles Homeless Services Authority (LAHSA) Point-In-Time (PIT) count reported its first decrease in the PIT homeless population in four years, with 52,765 individuals and family members experiencing homelessness.⁶ Between the 2018 and 2019 PIT counts, LAHSA reported preventing and ending homelessness for more people in LA County than ever before: 5,643 people were prevented from entering homelessness, 21,631 people were placed in homes, and 27,080 experienced other exits to housing. However, as documented by the 2019 PIT count, homelessness increased by 12% to 58,936 individuals in 2019. Los Angeles County continues to struggle with a large homeless population, roughly three-quarters of which, according to the 2019 PIT count, is unsheltered, with approximately 11,000 people living in tents or encampments and approximately 16,000 people living in cars, vans, or RVs/campers.

Programs and services administered through Measure H are varied, extensive, and involve multiple County agencies. While performance measures are tracked and reported regularly for each of the Measure H housing strategies, the complexity of service delivery and the multiple agencies and stakeholders involved requires a more in-depth evaluation to fully understand program functioning and need for program improvement. Fortunately, the Los Angeles Homeless Services Authority (LAHSA), which oversees these funds, implemented the Coordinated Entry System (CES) and Homeless Management Information System (HMIS) which provide a significant amount of data on how people enter and exit homelessness.

⁴ <https://homeless.lacounty.gov/about/>

⁵ Additionally, the U.S. Department of Housing and Urban Development (HUD) allocated \$109,398,295 to the Los Angeles Continuum of Care (LA CoC) for 2017 - an increase of nearly \$5 million from the previous year. The HUD Homeless Assistance Grant Awards include \$13.5 million for 11 new permanent supportive housing projects (PSH) providing 828 new permanent housing units. The overall award, with renewals, covers more than \$97 million for Permanent Supportive Housing.

⁶ The PIT count reflects number of people who meet the HUD standard for homelessness on a typical night in Los Angeles County.

Purpose

The purpose of evaluating the HI's interim housing strategies is to produce information that will facilitate these strategies in meeting their underlying objective to expand and enhance interim/bridge housing for those exiting institutions (Strategy B7) and enhance the emergency shelter system (Strategy E8), to determine best practices and areas in need of improvement, and to clarify how persons working directly with the homeless population define and understand program effectiveness and the degree to which this understanding is consistent with performance data. Additionally, this report examines differences in administration of various homelessness services funding sources and their impact on service provision.

Evaluation Objectives and Research Questions

Objectives

In procuring this HI strategy evaluation, as well as four others, the CEO specified four overall objectives to be addressed in the analyses:

Objective 1: To establish what the available data and performance evaluation results suggest are the strategy's best practices and to identify practices and processes in need of being re-visited and re-worked.

Objective 2: To reveal how persons working directly with the homeless population in the strategy define effectiveness and characterize the practices that the data suggest either bolster or impede strategy performance. Are their characterizations consistent with what the data show? If not, how do they understand the divergence?

Objective 3: To describe how specific funding sources affect the administration of a strategy and the capacity of strategy leads to deploy available resources effectively. To the extent that funding source restrictions create challenges in optimizing available resources, what are they and are there steps that can be taken to minimize them?

Objective 4: To detail instances in which strategy leads provide both services with Measure H funds and similar services not funded with these revenues. How does the administration of non-H-funded services and benefits differ from the administration of those funded with H dollars? What are the practical implications of this difference? Does the difference suggest non-H-funded homeless services would benefit from adopting practices specific to the H-funded portion of the same services and/or vice versa? How much does the answer to this question depend on the non-H funding sources and restrictions involved?

Additional Research Questions

In addition, specific research questions to evaluate Strategies B7 and E8 include:

Research Question 1: How do the Department of Health Services (DHS), the Department of Public Health (DPH)/Substance Abuse Prevention and Control (SAPC), and the Los Angeles Homeless Services Authority (LAHSA) B7 services differ in practice?

Research Question 2: How do bed rates affect interim housing shelter operations and outcomes?

Research Question 3: How does the provision of interim housing services differ by subpopulation and what are the challenges encountered in serving different groups? What are the operational challenges associated with the following types of services falling under strategies B7 and E8: DHS – Medical Recuperative, Psychiatric-Recuperative, Stabilization, DPH-SAPC Beds; LAHSA – Crisis, Bridge, Women’s, Transitional Housing for Domestic Violence Survivors?

Research Question 4: What is the quality of collaboration with the Department of Mental Health (DMH), Department of Children and Family Services (DCFS), Los Angeles County Sheriff’s Department (LASD), and Probation? What do each of these agencies do to support interim housing efforts and what is the significance and impact? Can coordination be improved or enhanced, and if so, how?

Research Question 5: What is the process and what challenges do hospitals face securing housing through B7 for inpatients/clients as required by the SB-1152 Hospital Patient Discharge Process? What is the potential role for Recuperative Care services for enhancing linkages from hospitals to interim housing?

Research Question 6: What is the potential for interim shelters to implement recovery-oriented principles into their environment and service delivery and how might that impact overall integration of services across sectors? (An example of recovery-orientation implementation is use of a person-centered assessment and planning process that incorporates the strengths and goals of individuals served and case management to support effective transition between treatment and service sites).

Research Question 7: What are the most difficult barriers to making transitions from interim housing to permanent housing?

Research Question 8: What are the differences among subpopulations (e.g., various sociodemographic groups, baseline substance use and mental health conditions) in outcomes including return to homelessness, permanent housing, and length of stay (LOS) in interim housing?

Methods and Data Sources

The primary objectives and research questions address program process and implementation, and methods included both qualitative data, including document review and in-depth interviews with program staff from LAHSA, DPSS, DHS, shelter provider staff, and hospital staff, and quantitative, secondary data from the LAHSA HMIS and DMH CHAMP databases. Table 1 presents a list of specific research questions, and their associated methods and data sources.

Table 1. Objectives, Methods and Data Sources

Objective/Research Question	Method	Data Source
O1: Establish what the available data and performance evaluation results suggest are the strategy’s best practices	Document Review	HI program documents: <ul style="list-style-type: none"> • 2016 Strategies • 2018 Evaluation Report • HI Quarterly Reports

	In-depth Interviews	County agency staff Strategy leads Direct service providers Policy Summit notes
O2: How persons on the ground define effectiveness	In-depth Interviews Document Review	County agency staff Direct service providers HI Performance Reports
O3: Describe how specific funding sources affect the administration of a strategy	In-depth Interviews	Strategy leads County agency staff Direct service providers
O4: How does the administration of non-H-funded services and benefits differ from the administration of those funded with H dollars?	In-depth Interviews	Strategy leads County agency staff Direct service providers
RQ1: How do the DHS, DPH/SAPC and LAHSA B7 services differ in practice?	Document Review In-depth Interviews	County agency staff
RQ2: What difference do bed rates make to operations and outcomes?	In-depth Interviews	Direct service providers
RQ3: How does the provision of interim housing services differ by subpopulation and what are the challenges encountered in serving different groups?	In-depth Interviews	Direct service providers Policy Summit notes
RQ4: : What is the quality of collaboration with DMH, DCFS, LASD and Probation?	In-depth Interviews	County agency staff Strategy leads Direct service providers
RQ5: What is the process and challenges experienced by hospitals in securing housing through B7 for inpatients/clients as required by SB-1152 Hospital Patient Discharge Process?	In-depth Interviews	DHS staff County hospital staff Private hospital staff
RQ6: What is the potential for interim shelters to implement recovery-oriented principles into their environment and service delivery?	In-depth Interviews	Direct service providers
RQ7: What are the most difficult barriers to making transitions from interim housing to permanent housing?	In-depth Interviews	County agency staff Direct service providers Policy Summit notes
RQ8: What are the differences among subpopulations in return to homelessness, permanent housing, and length of stay in interim housing?	Quantitative Analysis	HMIS data CHAMP data

Data Collection

New data collected were qualitative in nature. We also obtained and analyzed secondary, quantitative data from administrative data sources.

Qualitative Data Collection

We conducted a total of 25 in-depth, semi-structured interviews with county agency staff, direct service providers, and hospital staff between July and October 2019. Table 2 lists the department and provider staff interviewed by position title. See Appendix B for a complete list of all individuals interviewed. The process began with the CEO contact, Max Stevens, emailing one primary contact at DHS, DMH, and LAHSA, introducing the HMA project manager, Charles Robbins. HMA then scheduled introductory/fact finding meetings with each lead to explain the evaluation and request information including names of additional staff. We then selected in-depth interview participants, ensuring representation from each county agency. Shelter providers were selected to represent most of the Service Planning Areas (five of the eight SPAs were represented), large and smaller shelters, geographic diversity, and shelters targeting specialty populations.⁷

In addition, HMA staff attended the Homeless Initiative Policy Summit #4: Interim Housing on October 15, 2019, where multiple department and shelter provider staff had an opportunity to discuss their perspectives on several similar issues. Notes from this summit are also included in the qualitative component.

We developed semi-structured interview guides to address all objectives and research questions listed above. Interview guides were unique to different types of respondents, with one guide for County staff, one for provider staff, and one for hospital staff (see Appendix C for interview guides).

Mr. Robbins and Dr. Riehman led the in-person interviews, with Rathi Ramasamy attending and taking detailed notes. The interviews were recorded. Interviews were scheduled at times and locations that were convenient to participants and lasted 45 minutes to one hour.

Table 2. Key Informant Interviews

KEY INFORMANT INTERVIEWS	
DHS	<ul style="list-style-type: none"> + H4H Director of Interim Housing + H4H Director of Access, Referrals, and Engagement + H4H Program Implementation Manager
CEO	<ul style="list-style-type: none"> + CEO Senior Analyst + CEO Principal Analyst + HI Principal Analysts

⁷ HMA made multiple attempts to contact and interview SAPC staff but were unable to do so. Thus, findings related to SAPC services and perspectives on Measure H interim and emergency housing are lacking for this evaluation.

LAHSA	<ul style="list-style-type: none"> + Crisis Housing Coordinators + Manager of System Components + Interim Housing Placement Coordinator
DMH	<ul style="list-style-type: none"> + Mental Health Clinical Program Head
Shelter Staff (program directors, clinical & interim housing leads)	<ul style="list-style-type: none"> + LA Family Housing (SPA 2)- crisis and bridge + PATH Hollywood (SPA 4)- interim/ bridge + Path W Washington (SPA 6)-interim/ bridge + First To Serve (SPA 7)- crisis and bridge + Weingart (SPA 4)- crisis and bridge + Illumination Foundation (SPA 3)- recuperative care + Center for the Pacific Asian Family (SPA 4)- interim/ bridge + Haven Hills (SPA 2)- interim/ bridge + Los Angeles LGBT Center (SPA 4)- crisis, interim/ bridge
Hospitals	<ul style="list-style-type: none"> + DHS Director of Patient and Social Support Services + LAC USC Senior Clinical Social Worker + Harbor UCLA Clinical Social Worker Supervisor + MLK Hospital VP, Population Health + Huntington Memorial Hospital, Director of Care Coordination
Others	<ul style="list-style-type: none"> + Brilliant Corners + NHF (recuperative care)

Quantitative Data Collection

Quantitative data included HMIS data provided by LAHSA, CHAMP data provided by DHS, and aggregate DMH and SAPC administrative data prepared by CEO's research unit. HMA developed a list of data requests and submitted this to the County CEO contact. The quantitative HMIS and DHS/CHAMP data are individual level, de-identified data.

Data Analysis

Qualitative Data Analysis

For qualitative data, detailed notes taken during each interview were examined using specialized qualitative data analysis methods. Interviews were also recorded as back-up and confirmation of notes. Codes were developed to reflect each research question and analysis was conducted by question, with key themes identified, and illustrative examples highlighted.

Quantitative Data Analysis

The quantitative analysis focused on two questions assessing the client experience: 1) What are the differences among subpopulations in return to homelessness, permanent housing, and LOS in interim housing? 2) To what extent do those discharged from institutions to interim housing and needing physical health, mental health or substance abuse services receive services?

HMIS Data Sample

The HMIS sample constructed for this analysis included adult heads of household enrolled in either emergency or transitional housing, with entry date on or after July 1, 2017, and with valid exit date following July 1, 2017 (see Appendix D for details on sample selection). HMIS data primarily tracks persons receiving interim housing services through LAHSA, with relatively little overlap with services provided through DHS (described below). The total sample size for analysis was 20,574 adults.

Demographic variables were defined as per the “HMISSCVSpecifications6_11” data dictionary. Analysis included bivariate comparisons in mean differences (using one-way ANOVA for multiple group comparison) and categorical differences (using chi-square) in exit to permanent housing, LOS, and exit to homelessness, among the following subpopulations: ethnicity, race, gender, veteran status, domestic violence, substance abuse problems, mental health problems, and Coordinated Entry System (CES) score, which uses the Vulnerability Index-Service Prioritization Decision-Assistance Tool (VI-SPDAT) to assign a score to determine the best type of permanent housing solution.

- Ethnicity
 - + Non-Hispanic/Non-Latino, Hispanic/Latino, Other (Client doesn’t know, client refused, data not collected)
- Race
 - + White, Black/African American, Mixed Race (assigned if more than one category was identified), Other (American Indian/Alaska Native, Native Hawaiian/Other Pacific, Race - none)
- Gender
 - + Female, Male, Transgender (Trans Female-Male to Female, Trans Male-Female to Male)/Non-conforming, Other (Client doesn’t know, client refused, data not collected)
- Veteran status
 - + Veteran, Non-Veteran, Other (Client doesn’t know, client refused, data not collected)
- Disability status
 - + Mental health disability, No mental health disability
 - + Substance abuse disability, No substance abuse disability
 - + Mental health problems only, Substance abuse problems only, Mental health and substance abuse problems, No mental health/substance abuse problems
- CES score
 - + 0-3, 4-7, 8+

Client experience outcome variables included total number of days in the program across all years (calculated as total days across all stays), exit to permanent versus non-permanent housing, and exit to homelessness. Exit to permanent housing was defined as any of the following values for ‘Destination’ in the Exit data file: 3-permanent housing (other than RRH) for formerly homeless persons; 10-rental by client, no ongoing housing subsidy; 11-owned by client, no ongoing housing subsidy; 20-rental by client, with other ongoing housing subsidy; 21-owned by client, with ongoing housing subsidy; 22-staying or living with family, permanent tenure; 23-staying or living with friends, permanent tenure; 26-moved from one HOPWA funded project to HOPWA PH; 27-moved from one HOPWA funded project to HOPWA TH; 28-rental by client, with GPD TIP housing subsidy; or 29-residential project or halfway house with no

homeless criteria. Exit to homelessness was defined as ‘Destination’ = 16-place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway stations/airport or anywhere outside).

CHAMP Data Sample

The DHS/CHAMP sample constructed for this analysis included all unique individual cases included in the Interim Housing datafile with check-in date on or after July 1, 2017, and a valid check-out date (See Appendix D for details on de-duplication of CHAMP data file). All de-duplicated records were included in the analysis sample. CHAMP data track persons receiving recuperative and stabilization housing services predominantly through DHS. The total sample size for the analysis was 3,489 persons.

Analysis included bivariate comparisons in mean differences (using one-way ANOVA for multiple group comparison) and categorical differences (using chi-square) in exit to permanent housing and LOS among the following subpopulations: ethnicity, race, gender, veteran status, and housing type.

- Ethnicity
 - + Non-Hispanic/Latino White, Hispanic/Latino, Other/Unidentified
- Race
 - + White, Black/African-American, Mixed Race, Other/Unidentified
- Gender
 - + Female, Male
- Veteran status (Served in Armed Forces)
 - + Veteran, Non-Veteran, Unknown
- Housing type
 - + Stabilization, Recuperative

Information on the mental health, SUD and domestic violence statuses of clients in our DHS sample was not available for this analysis.

Client experience outcome variables included total number of days in the program across all years (calculated as total days across all stays), total number of program stays (calculated as total number of check-in dates), and exit to permanent versus non-permanent housing (Interim_Housing_Exit_Reason = ‘Move to Permanent Housing’). There was no indicator for exiting to homelessness, thus this outcome is not analyzed for the CHAMP data.

Summary of Results

Results are organized by research question, with all relevant qualitative and quantitative data presented. We present first the results for the specific research questions. We then present results for the overall program evaluation objectives, to which the research question results contribute.

Differences in interim housing services among agencies

Interim housing service provision among agencies is differentiated by the populations targeted, specifically their physical and behavioral health needs. DHS, for example, primarily provides recuperative care and stabilization housing for individuals requiring assistance with physical ailments, while LAHSA provides shelter services for persons not needing assistance with physical ailments and/or daily living.

Stabilization housing consists of room and board, case management, transportation to appointments, and support in getting ready to be permanently housed. Recuperative Care housing adds a layer of medical and mental health oversight, including services such as wound care, response to health emergencies, and other medical assistance needed. LAHSA shelter services also include case management services similar to those provided by DHS, though again working with a population with less acute health needs. LAHSA's enhanced bridge housing also has licensed clinical care management staff.

As described by DHS and LAHSA staff, case management services provided in practice are similar across populations and shelter types, with the primary focus on case management to move individuals to permanent housing, regardless of acuity level.

DMH provides shelter beds and services for individuals requiring mental health services or existing institutions, or who may have co-occurring mental health and substance use disorders. SAPC provides beds for recovery services, typically for about 90 days, after which time individuals are often referred to DHS for further housing needs.

The referral process among DHS, LAHSA, and DMH is well coordinated, with daily communication to determine appropriate placement among those referred from all sources. The coordinated referral and placement system is further strengthened by co-located DHS and DMH staff. Several key informants noted that there are some issues with inaccurate initial acuity level assessment, but that these are fairly quickly identified, and individuals are re-assessed for more appropriate placement.

Bed rates

Shelter staff expressed appreciation for the fact that bed rates have increased since the inception of Measure H. However, almost all shelter staff indicated that the current bed rates are still not sufficient to provide the level of service they feel clients need, particularly because the clients they are serving have complex needs. Shelter staff who could recall their current bed rates reported rates between \$44 and \$82 per night and stated that bed rates between \$80 and \$100 would be optimal. County staff indicated that they were aware of this desire for higher bed rates.

A higher bed rate could be leveraged to better serve clients by allowing for enhanced services and staffing, particularly having licensed staff on site. Several shelter key informants stated that they experience operational challenges during non-traditional hours, and higher bed rates would allow them to hire licensed staff to be on site after hours to manage crises. Staff also expressed that because most clients have a number of complex, co-occurring needs, they would benefit from an expanded portfolio of services including workforce development programs, enhanced case management, on-site health and mental health services to ensure ease of access, and "life skills" training including financial literacy. Higher bed rates could also help support facility costs, security, and food.

Differences in services among subpopulations and challenges serving subpopulations

Several challenges unique to serving specific subpopulations were identified. Medical recuperative care providers stated that because their clients have such high acuity levels requiring assistance with daily living, they can be “hardest to house” and sometimes needed a longer length of stay to stabilize than a client without any medical issues. Key informants indicated that it was difficult for clients to focus on connecting with housing resources and managing their medical issues at the same time.

Shelter staff serving Transitional Age Youth (TAY) expressed a need for more services that are TAY-specific. While TAY need many of the same services as other clients experiencing homelessness, such as employment support, family/parenting support and financial literacy, TAY experience these challenges in a different way and would benefit from service delivery tailored to their age group. During the policy summit, stakeholders also expressed challenges that TAY face with safety while in shelters with all other age groups. While shelters have generally adopted a harm reduction approach to substance use disorder, stakeholders stated that environments in which TAY are exposed to other clients’ substance use could be harmful for them. For clients with substance use disorder, key informants stated that more time was needed to build rapport and engage them in services to get them ready for housing.

Providers serving domestic violence victims indicated an additional layer of challenges due to the level of trauma their clients have faced. Shelter staff expressed concern that survivors of domestic violence are not prioritized in the system and stated that their clients are in particular need of trauma-informed care. Key informants emphasized that some standard practices such as diversion as a first-line strategy are inappropriate for domestic violence survivors—victims often share friends and family with their abusers, and they cannot rely on their own network for safety. They also indicated that domestic violence is likely underreported in HMIS data, as victims may not clearly understand the question on the CES intake survey, “Are you fleeing because you are in danger?”

Shelter providers serving LGBTQ individuals expressed a need for more staff with a clinical background in order to provide more mental health services. Providers also requested that the homeless system of care prioritize the LGBTQ population by protecting resources for them.

Key informants serving immigrant, monolingual, and Limited English Proficient clients expressed challenges with a lack of culturally appropriate services for these populations, particularly in Asian/Pacific Islander communities. Shelter staff serving these clients stated that monolingual clients faced a great deal of difficulty accessing resources simply because it is so hard for them to navigate the system. Key informants specifically offered the example of the VI-SPDAT assessment only being offered in English and Spanish, making it extremely difficult to accurately complete for monolingual clients speaking any other language. Key informants also stated that there is a lack of resources for undocumented immigrants experiencing homelessness, particularly in more remote areas of the county.

Key informants also expressed a few operational challenges in working with specific subpopulations. Almost all shelter key informants indicated that they are receiving funding from multiple sources, many with different restrictions, requirements and objectives that may apply to different populations. However,

they stated that this did not impact service delivery and is generally not detected from the perspective of the clients, but mainly creates some administrative burden in terms of reporting and paperwork.

Collaboration among County agencies, providers

The regular, ongoing, and highly collaborative interaction among key agencies, including DHS, LAHSA DMH and the HI, resulting from the Measure H initiative, is one of the key strengths of the program. Regular monthly meetings among the lead agencies (DHS, DMH, LAHSA, CEO's office) offer leadership the opportunity to discuss high level issues around funding, spending, and broader program issues. Quarterly meetings involving additional agencies such as DCFS, LASD, and Probation are also held. LAHSA has conducted several trainings for law enforcement on the referral system for LAHSA and DHS. One key informant noted that collaboration with probation tends to occur with individual shelter providers to identify individuals appropriate for placement under B7.

A key indicator of successful collaboration is the development of shelter standards of care that were implemented in September 2019 by DHS, LAHSA, and DMH. Prior to Measure H, consistent standards across shelter types and agencies did not exist. The sheer increase of beds as a result of Measure H prompted the recognition that standards were crucial to consistent and high-quality service provision. The development of standards also included participation by DPH, who developed the facilities standards component. Key informants also mentioned the development of a universal housing referral form used by DHS, DMH, and LAHSA, as an indicator of successful collaboration.

High Quality of Collaboration: According to one key informant, 'the level of coordination and collaboration is unlike anything I have ever seen in the county.'

Several key informants and individuals attending the Policy Summit noted that despite substance use disorders being a major issue for many individuals, SAPC participation is lacking at the leadership and programmatic level. Some shelter providers recommended that SAPC provide substance abuse services on-site. It was also noted that some agencies such as DHS, DMH and DPH collaborate very well because they are under one umbrella; however, structural issues within other agencies such as DPSS and DCFS make it more difficult for those staff to easily collaborate. One key informant noted that for some agencies, including the sheriff's office and probation, involvement in addressing issues of homelessness is relatively new, and the idea has 'taken hold unevenly in some agencies.'

Measure H has also resulted in a closer collaborative relationship between DHS, LAHSA, and shelter providers. Several DHS staff and shelter providers noted that the close collaborative relationship offers the opportunity to regularly discuss individual cases and engage in problem-solving at the client level. Also noted was the importance of training provided by DHS and LAHSA to shelter providers. LAHSA is currently developing Learning Communities with providers to encourage sharing of best practices.

Process and challenges for hospitals

The process for hospital referral for strategy B7 is similar for county hospitals and private hospitals interviewed, although access to DHS recuperative care housing differs. The county hospitals have well-

established referral pathways to DHS for recuperative care/stabilization housing, with DHS-funded staff on site who, along with many hospital staff working with the homeless population in emergency departments, have direct access to the DHS CHAMP data system. The county hospitals have a specific protocol for initiating the referral process for homeless individuals directly in CHAMP. One hospital has a dedicated team of homeless staff – the Homeless Task Force – focused on working with this population for assessment and referral. This team is partially funded by the hospital’s operational budget. Another county hospital reported no dedicated homeless team, but all staff have experience with and are comfortable working with the homeless population and their unique needs.

In private hospitals, staff do not have access to CHAMP and rely on direct communication with DHS staff to identify potential recuperative care beds for their patients. One key informant noted that referral to DHS recuperative care/stabilization housing is prioritized for the county hospitals, and while their preference would be DHS housing, most often DHS is not able to accommodate patients referred from private hospitals. Another private hospital informant was completely unfamiliar with the DHS referral process, had never referred to DHS, and was not aware that they might have access to DHS recuperative care beds.

In both the county and private hospitals, identification of potentially homeless individuals begins immediately after, and sometimes before, the actual intake process. One

county hospital staff described how their Homeless Task Force goes into the emergency department (ED) waiting room and looks for individuals who appear to be homeless, including those with a lot of belongings or suitcases with them. Another public hospital staff described checking the hospital’s tracking system proactively to identify homeless individuals prior to them being referred to her for assistance. For all county hospitals, determination of potential housing needs is a routine part of the intake and release process. The CHAMP system allows referring staff to quickly and easily identify whether an individual is already in the system or whether a new referral initiation is needed. Once the referral process is initiated in CHAMP, DHS sends a Recuperative Care staff person to the hospital to interview the patient, review records, and determine whether the patient requires Recuperative Care or other appropriate housing. This then leads to the overall process of moving individuals to permanent housing.

One informant observed that the hospital setting is a key location for identification and referral of homeless individuals. Some homeless individuals go to the ER to find a place to sleep for the night. She also described how many individuals spend time on the hospital campus because they have no other place to go during the day. Another staff indicated that word has spread about their Homeless Task force, and in some cases individuals without health problems show up at the ER for housing services.

Role of recuperative care for linking from hospitals to interim housing: “So maybe they go into recuperative care, but then if they are willing and able to kind of move through the rest of the process to get into some other like transition or permanent supportive housing, they’ll do that and their team really serves as housing navigators.”

Potential to implement recovery-oriented principles

Because of Measure H and the expansion of interim housing beds, shelter providers have significant potential to incorporate recovery-oriented principles into their programs. These principles include using a person-centered, strengths-based approach to recovery that focuses on empowerment, peer support, respect, and individual responsibility.⁸ Shelters are already applying a Housing First approach and focus on harm reduction in addition to recovery support. Providers have received training from LAHSA in trauma-informed care models, which can be further strengthened through the Learning Collaborative and sharing of best practices. All B7 and E8 shelters are required to provide case management services that include a wide array of person-centered services.

However, challenges to this person-centered approach were identified. Several participants in the Policy Summit specifically noted that the focus on harm reduction has made it difficult for individuals who are interested in sober living and recovery. With the increased size of interim housing facilities, individuals are exposed to other individuals who use substances, making it more difficult to achieve and maintain their own sobriety. Recommendations included allowing and designating some facilities as sober living facilities, in which an individual can choose to be assigned to this type of facility.

Another challenge includes the need for more experienced and highly trained staff to work with complex cases. Many providers do not have sufficient funds to hire staff with the level of experience required for this population. At a minimum, more training for existing staff should be provided to increase their skill set and ability to work with individuals with complex needs.

Challenges transitioning to permanent housing

Lack of permanent housing in the County was the most frequently cited barrier to transitioning to permanent housing identified by key informants. Both County agency staff and shelter staff agreed that a lack of permanent housing resources creates a bottleneck, leading to slow bed turnover in interim housing.

Another frequently cited barrier was the difficulty for clients with high acuity level needing assistance with daily living, and those with mental health and/or substance use problems, to gain skills needed to live independently. Key informants emphasized the importance of supportive services such as workforce readiness, financial literacy, and budgeting classes as crucial for clients to be able to maintain housing once they transitioned. However, key informants also stated that workforce development and job training programs are often still insufficient due to the high cost of living in Los Angeles, as even a full-time minimum wage job might not be sufficient to maintain housing stability.

Because CES matching is based on availability and eligibility rather than client needs, key informants also stated that it is difficult to achieve care continuity in scattered site permanent housing. Clients often build rapport with service providers in shelters, and it can be a challenge to transition to a different location with new staff. Key informants also discussed the importance of community, and the fear that many clients grapple with once moving into permanent housing and losing the social support they had relied on

⁸ <https://www.apa.org/monitor/2012/01/recovery-principles>

from other clients in shelter. This was a commonly mentioned challenge particularly for clients with mental health and substance use disorder needs.

In terms of CES prioritization, key informants stated that clients in interim housing are not necessarily next in line for permanent housing resources. One key informant expressed a need for a strategy to prioritize those in beds for permanent housing to improve throughput in the system.

Differences among subpopulations in outcomes

We examined differences in outcomes among various client subpopulations related to exits to permanent housing (PH), returns to homelessness, and LOS in interim housing. We first present results for the HMIS sample, which includes those in interim housing served predominantly by LAHSA. We then present results for the population receiving Recuperative Care and Stabilization Housing through DHS and tracked in the DHS CHAMP data system.

HMIS Sample

Table 5 presents the demographic, health status, and outcomes for the entire HMIS sample analyzed. Most were Non-Hispanic/Non-Latino (72%) with about 27% Hispanic/Latino. Over 50% were Black/African-American, followed by 38% White. Almost 60% were male and about 11% were veterans.

Almost 30% of the sample had experienced domestic violence upon entry to the program, 43% had a mental health problem, almost 20% had a substance abuse problem, and almost 14% presented with co-occurring mental health and substance abuse problems. Almost one-quarter of the sample had exited to permanent housing, 8% exited to homelessness, and the average length of stay was 99 days.

Table 3. Demographics, Health Status, and Outcomes

Sample Demographics	Number	Percent
Total	20,574*	
Ethnicity		
Non-Hispanic/Non-Latino	13,820	72.0
Hispanic/Latino	5,513	26.8
Other	241	1.2
Race		
White	7,886	38.3
Black/African-American	10,773	52.4
Mixed	426	2.1
Other	1,489	7.2
Gender		
Female	7,984	38.8
Male	12,252	59.6

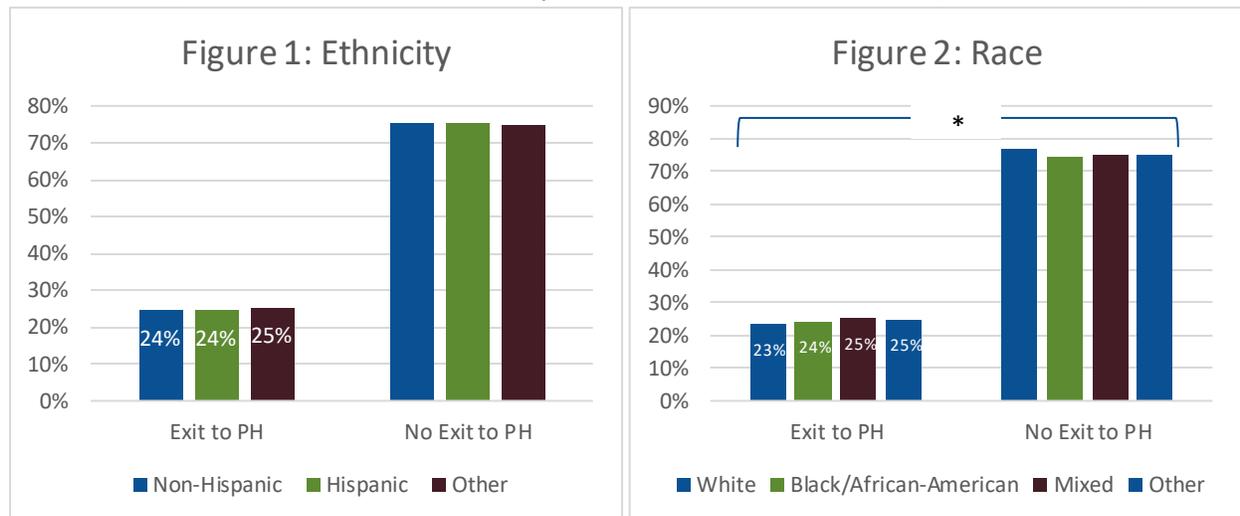
Transgender/Non-conforming	270	1.3
Unknown/Refused	68	0.3
Veteran Status		
Veteran	2,300	11.2
Non-Veteran	17,926	87.1
Other/Unknown	348	1.7
Health Status		
	Number	Percent
Domestic Violence		
Experienced DV	6,106	29.7
No DV	14,468	70.3
Mental Health Problem		
Yes	8,851	43.0
No	11,723	57.0
Substance Abuse Problem		
Yes	3,987	19.4
No	16,587	80.6
Mental Health and Substance Abuse Problem		
Substance abuse only	1,135	5.5
Mental health only	5,999	29.2
Both SA and MH	2,852	13.8
No MH or SA	10,588	51.5
CES Score		
0-3	1,989	16.2
4-7	4,826	39.4
8+	5,430	44.4
Client Experience Outcomes		
Exit to Permanent Housing	Number	Percent
Yes	5,020	75.5

No	15,534	24.5
Exit to Homelessness		
Yes	1,618	7.9
No	18,956	92.1
Length of Stay (Days)	99.3	109.5

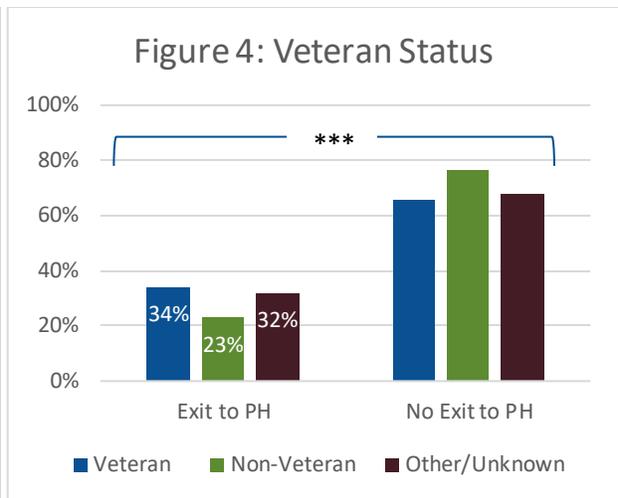
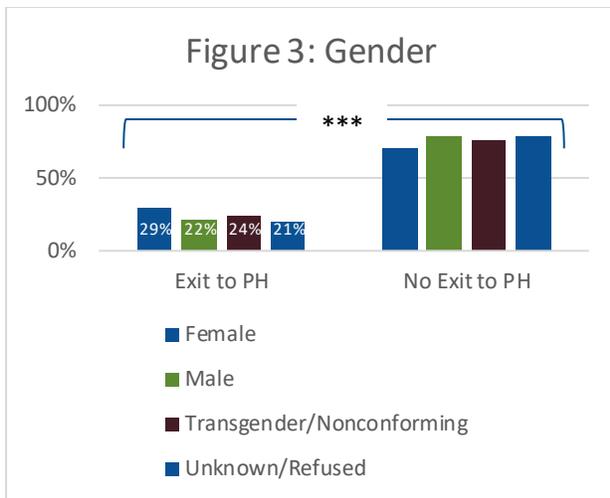
* Some variables have missing values so do not total to 20,574.

Exit to Permanent Housing

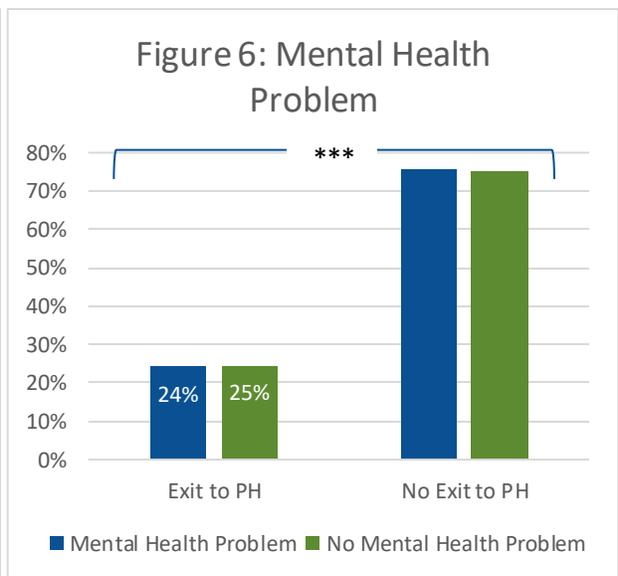
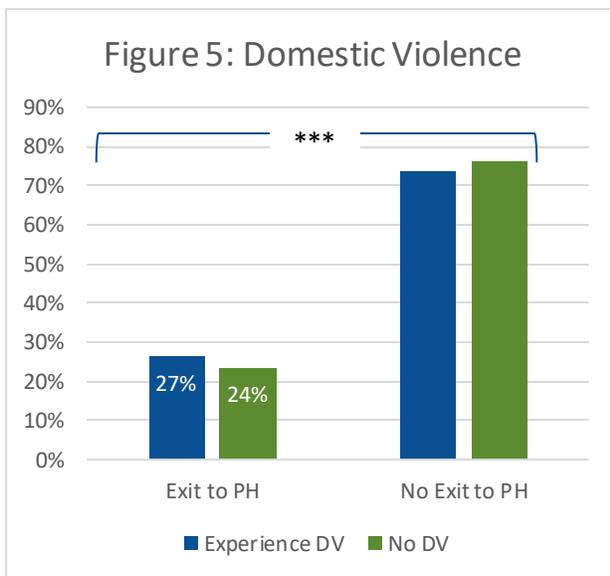
Figures 1 to 4 show differences in the demographic subpopulations in exit to permanent housing. There were no significant differences among ethnic groups in exit to PH, but there were significant differences by race, gender, and veteran status. Whites were the least likely to exit to PH (23% compared to 24% and 25% of Black and mixed race, respectively). Females were more likely than males to exit to PH (29% versus 21.5%), and veterans were more likely than non-veterans to exit to PH (34% versus 23%).

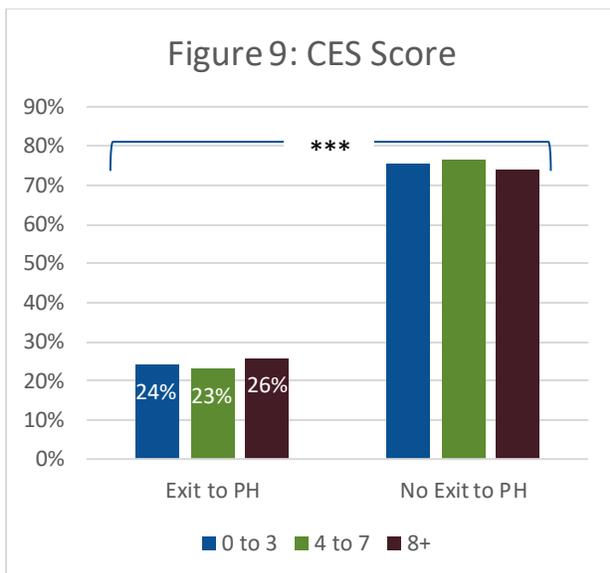
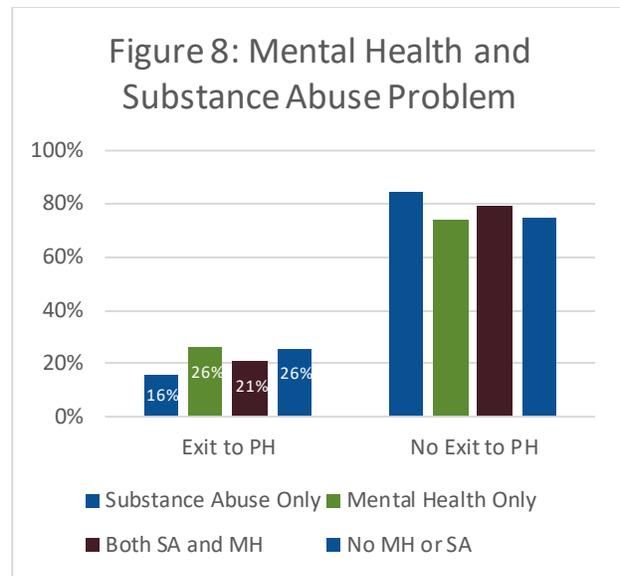
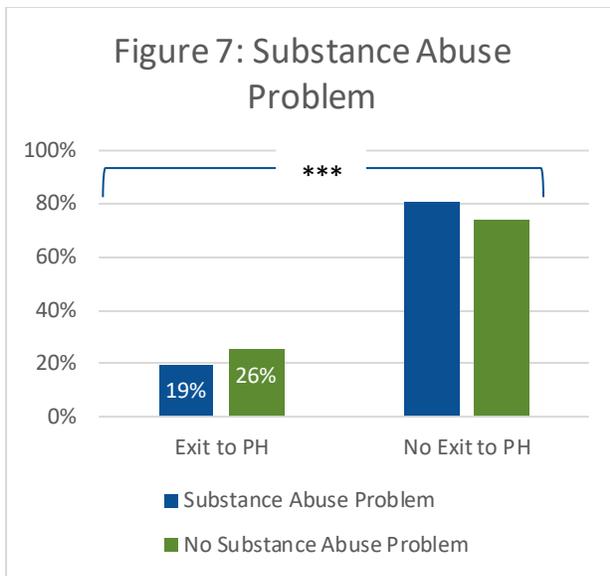


*p<0.05
 ** p<0.00
 *** p<0.000

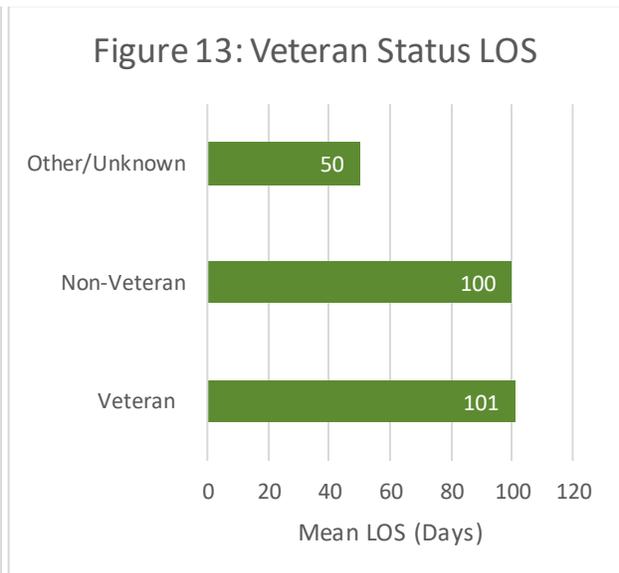
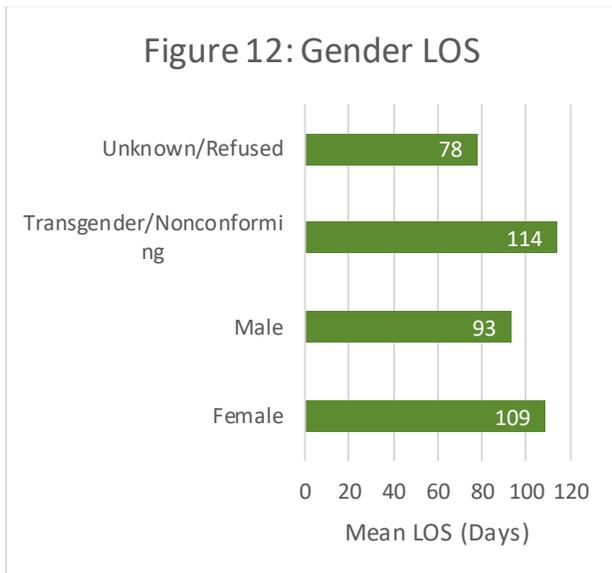
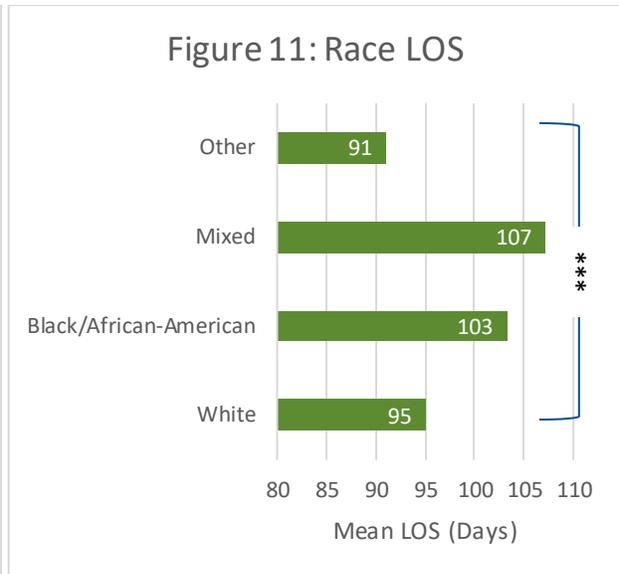
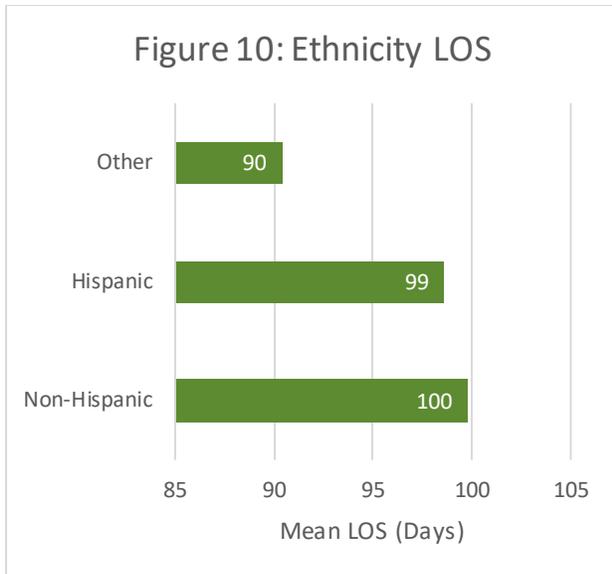


Figures 5 to 9 show that significant differences among subpopulations in exiting to PH were also found for those with domestic violence, substance abuse problems, and co-occurring mental health and substance abuse problems, while no differences were found among those with only mental health problems. Individuals experiencing domestic violence, those without substance abuse problems, and those with mental health only or no mental health problems were more likely to exit to PH. Those with the highest CES score were most likely to exit to PH (26% compared to 24% of those in the lowest and 23% of those in the mid-range groups).

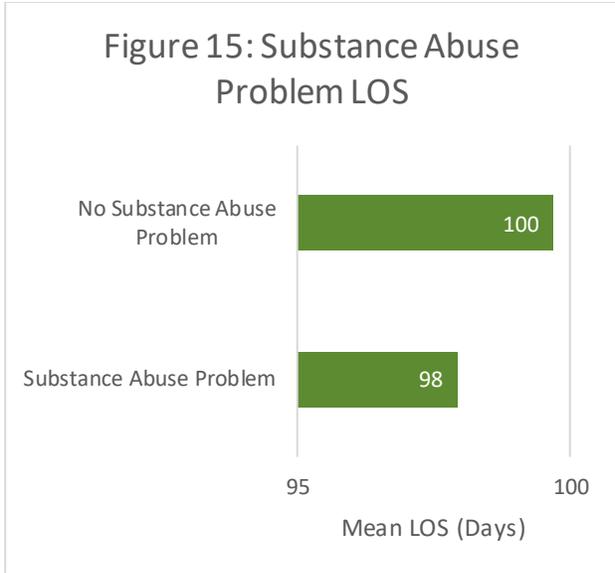
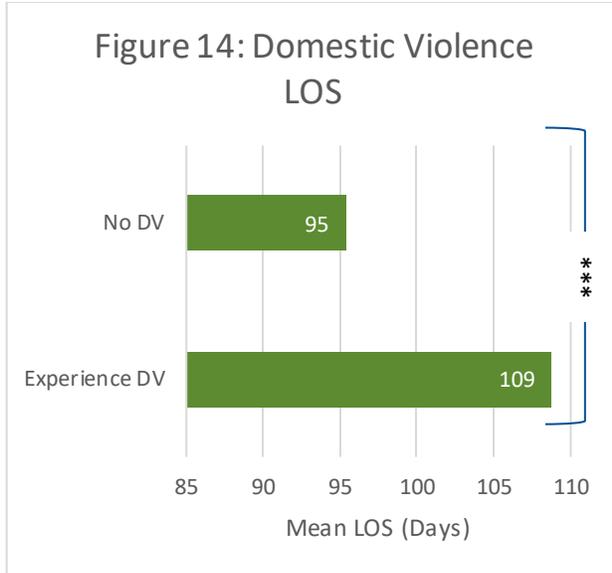


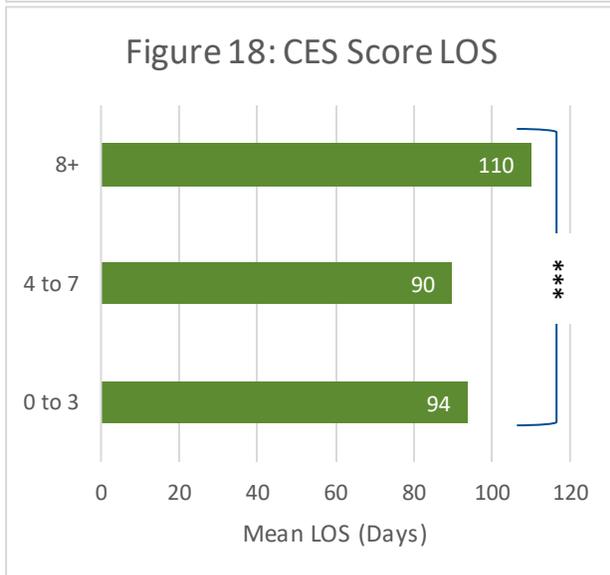
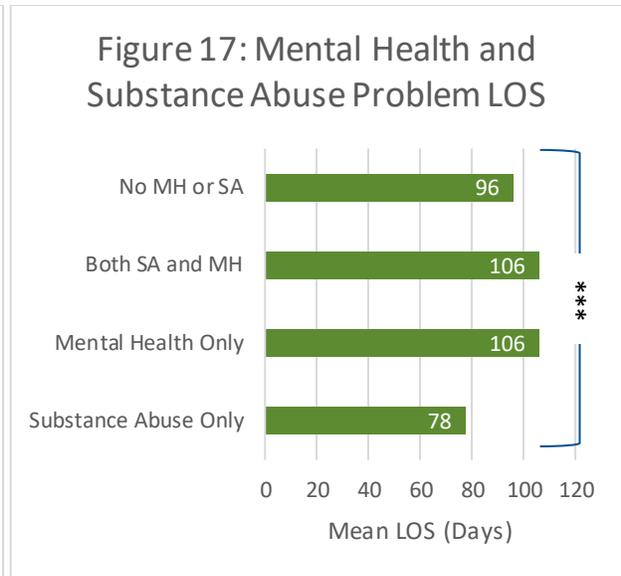
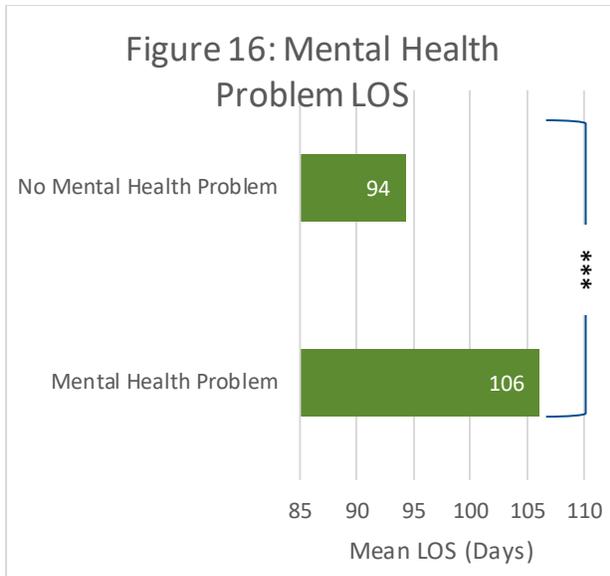


Figures 10 to 18 show subpopulation comparisons for LOS. There were no differences in LOS by ethnicity, but significant differences were found in the other demographic subgroups. Those with mixed race had the longest LOS (107 days) compared to ‘other’ and whites who had the shortest LOS (91 and 96 days, respectively). This may be reflective of whites and ‘other’ being less likely to exit to PH (it is possible these groups terminate the program early, prior to finding PH).



Among the health status subgroups, those experiencing domestic violence had a significantly longer LOS (109 days compared to 95 days for those with no domestic violence history), and those with mental health problems compared to those without had longer LOS (106 versus 94 days, respectively). There was no difference in LOS for those with substance abuse versus those without substance abuse problems. Looking at the combined mental health and substance abuse grouping, however, those with co-occurring mental health and substance abuse problems and those with mental health problems only had the longest LOS (106 days for both). CES score was also associated with LOS, with those in the most severe category remaining the longest (118 days).

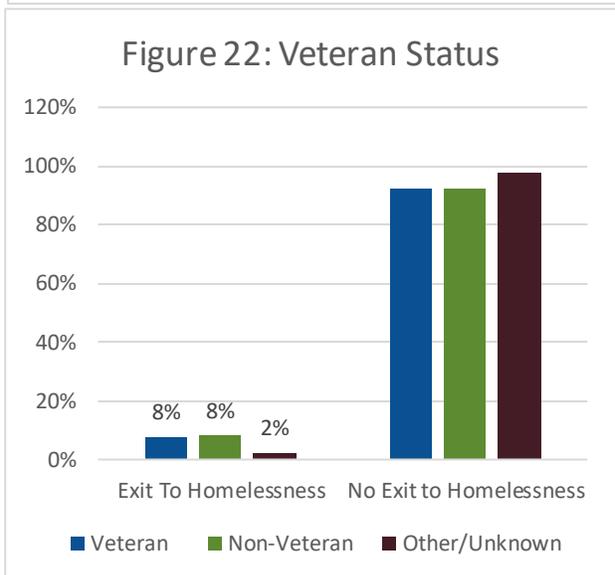
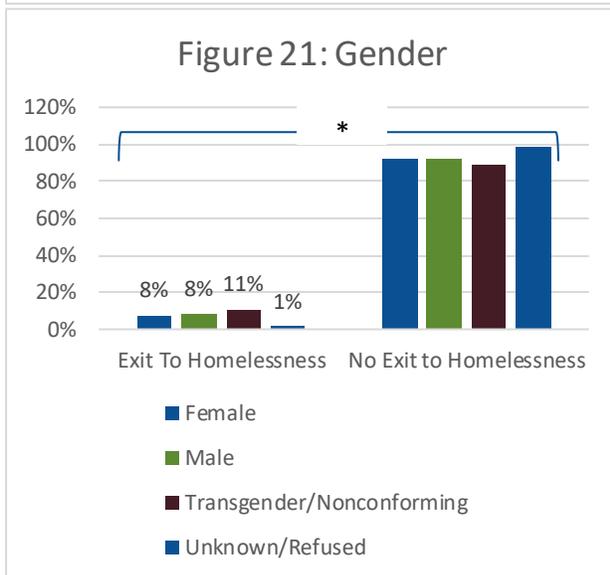
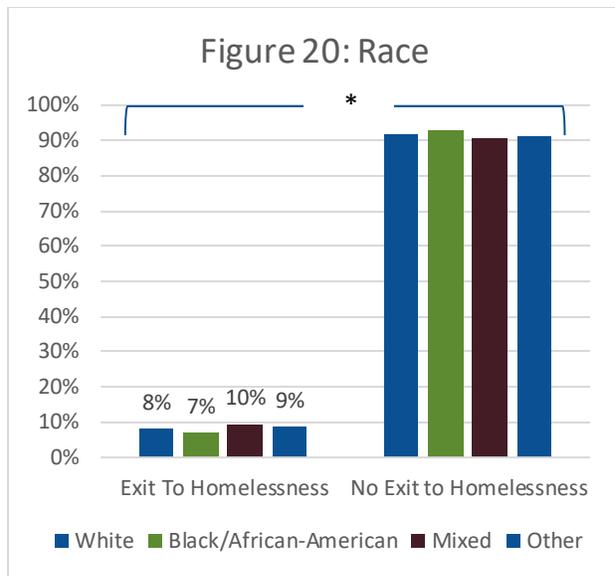
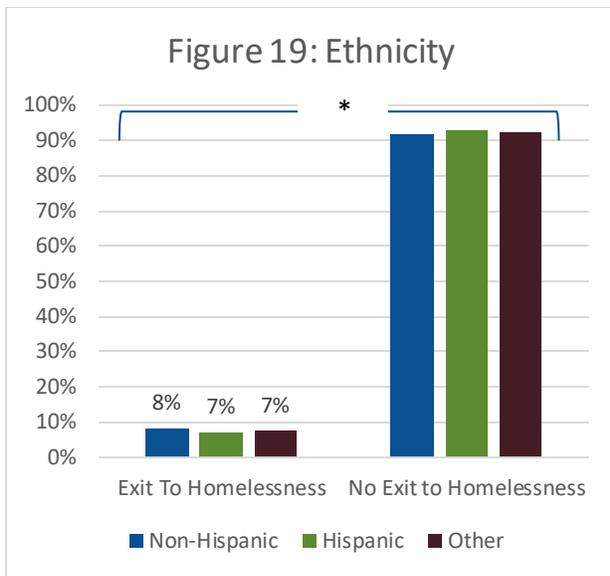




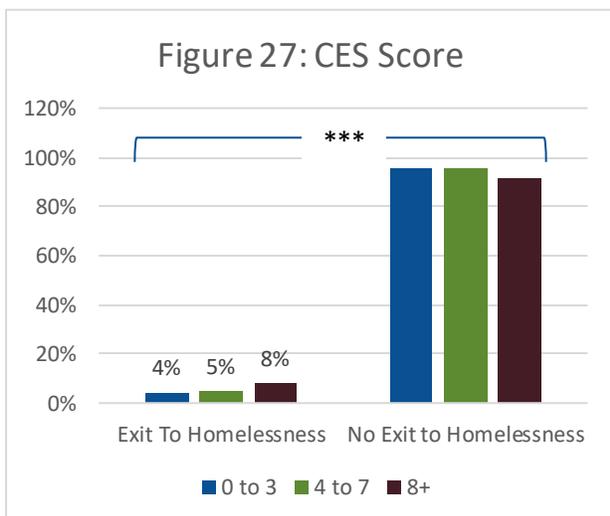
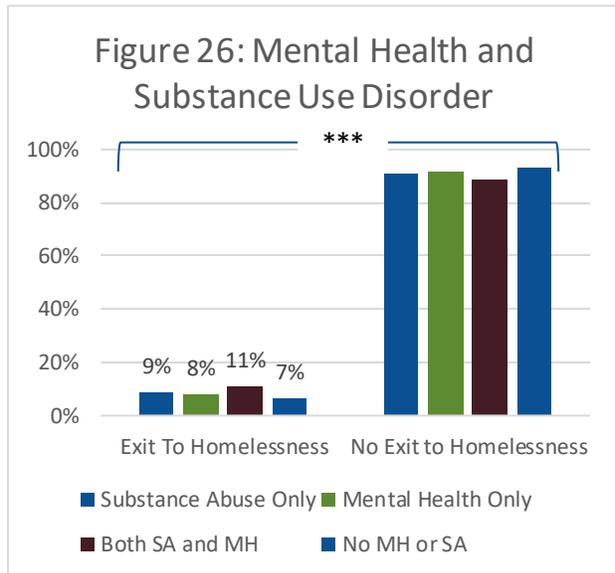
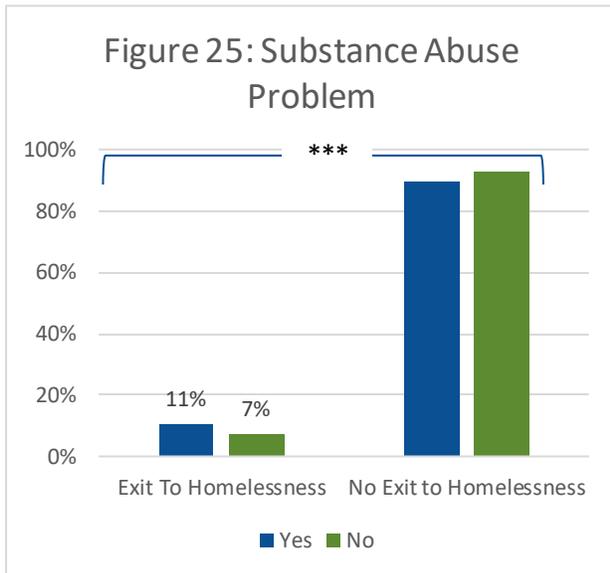
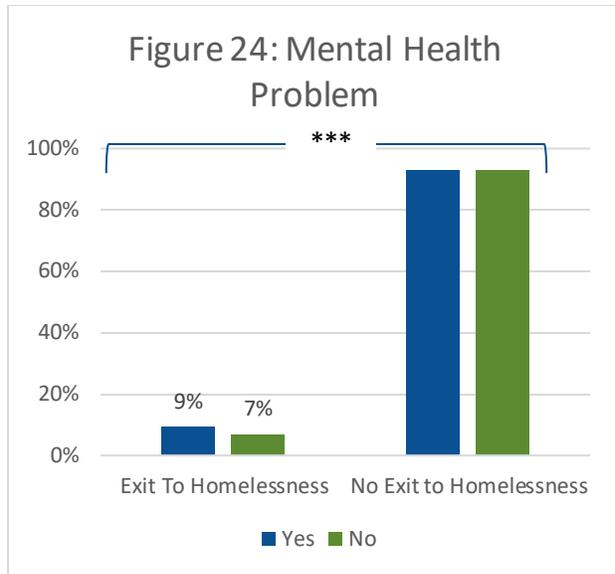
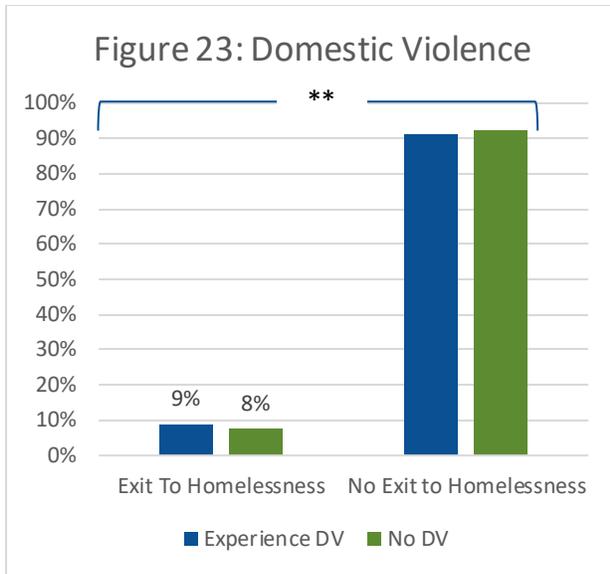
Exit to Homelessness

As illustrated in Figures 19 to 27, significant differences in exit to homelessness were found across all subgroups. Non-Hispanic/Non-Latinos, and those with mixed race were more likely than their comparison groups to exit to homelessness. Transgender/non-conforming individuals (11%) were significantly more likely to exit to homelessness compared to females and males (8% in each group).

There was a significant difference in the veteran group, but this may be driven by those with unknown status, with only 2% compared to 8% of those identified as veterans or non-veterans exiting to homelessness.



Those experiencing domestic violence (8%), those with mental health problems (9%) and those with substance abuse problems (11%) were more likely than their counterparts to exit to homelessness. Those with co-occurring mental health and substance abuse problems (11%) were more likely than the other categories to exit to homelessness. Those in the most severe CES category (8%) were twice as likely to exit to homelessness compared to the low and mid-range groups.



Summary for HMIS sample

Analysis indicates significant differences in all outcomes among various subpopulations; however, interpretation of these differences may be difficult. Exit to permanent housing is a positive outcome, but this is often accompanied by a longer length of stay. This is an example where longer LOS may be indicative of a positive outcome if individuals remain in a temporary shelter longer but end up in PH rather than non-PH living situations. Similarly, the significantly longer LOS for those with the highest acuity level may indicate that they are staying longer because they need to, compared to those with low acuity. However, data also indicate that for a subset of those with high acuity, exiting to homelessness is more likely, compared to those with lower acuity. Thus, individuals with high acuity are more likely to exit to homelessness, but if they stay in a program, they stay longer and are more likely to move to PH. The same is not true for those with co-occurring mental health and substance abuse problems, where they are the least likely to exit to PH and the most likely to exit to homelessness.

CHAMP Sample

The CHAMP data available to us did not include information on health status, thus analysis was more limited for examining subgroup differences. In addition, these data did not include information on whether individuals exited to homelessness, so we focus only on exit to PH and LOS. Table 6 presents the demographic information and outcomes for the CHAMP sample analyzed. Like the HMIS data, most of the sample were Non-Hispanic, White at 63%. White and Black/African-Americans were at about equal proportions (39 and 38%, respectively), with almost 70% male. Most individuals were in stabilization housing (65%) compared to those in Recuperative Care (36%). Like the HMIS population, 24% exited to PH, and the average LOS among those who had exited was 139 days, 40 days longer on average than in the HMIS population.

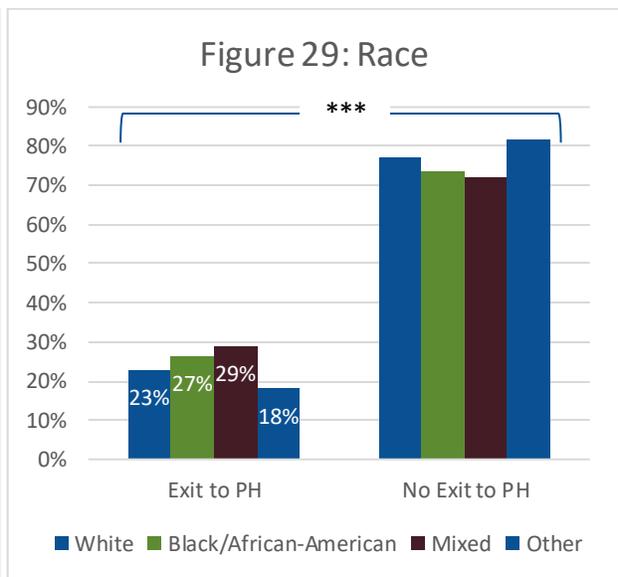
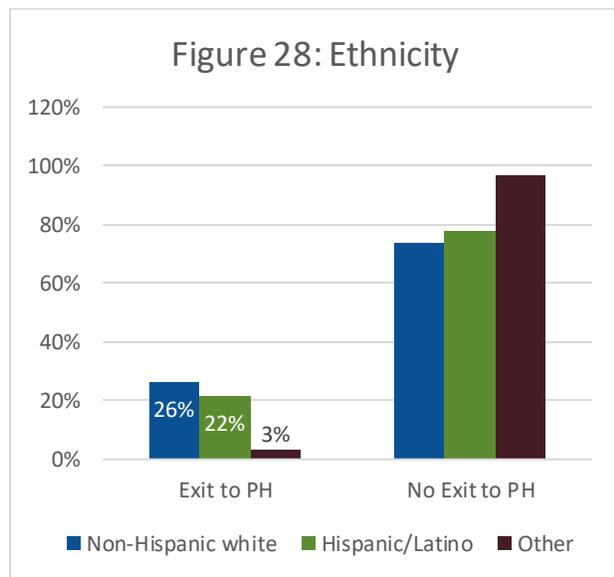
Table 4. Sample Demographics

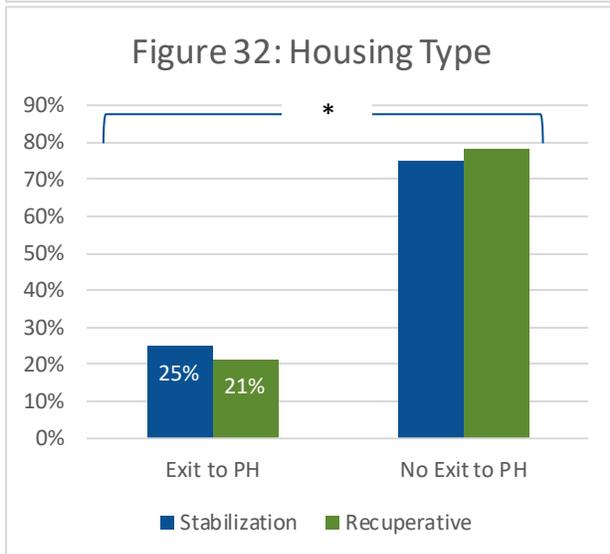
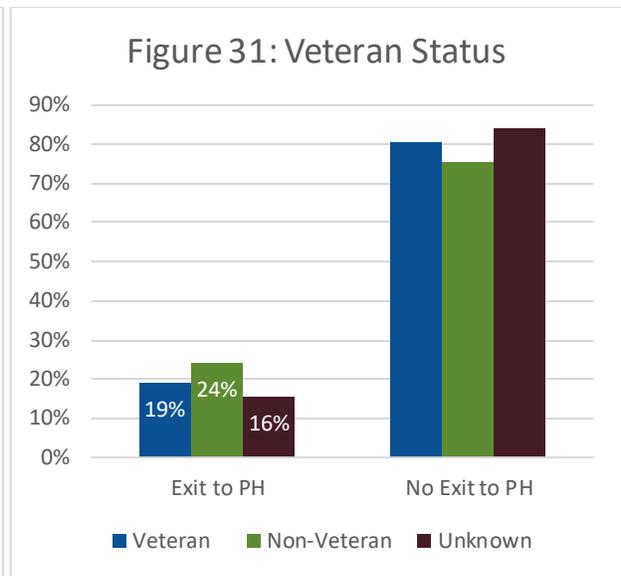
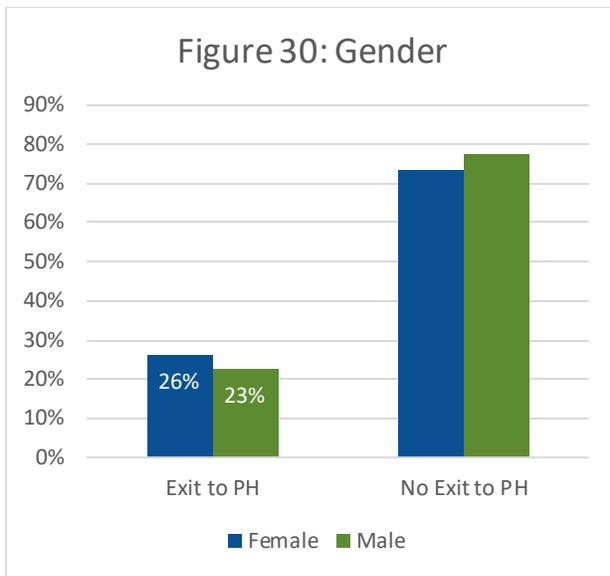
Sample Demographics	Number	Percent
Ethnicity		
Non-Hispanic/Non-Latino	2,202	63.1
Hispanic/Latino	1,140	32.7
Other	147	4.2
Race		
White	1,352	38.8
Black/African American	1,309	37.5
Mixed	267	7.6
Other	561	16.1
Gender		
Female	1,111	31.8
Male	2,378	68.2

Veteran Status		
Veteran	109	3.1
Non-Veteran	3,265	93.6
Unknown	115	3.3
Housing Type		
Stabilization	2,228	63.9
Recuperative	1,261	36.1
Exit to Permanent Housing		
Yes	833	23.9
No	2,656	76.1
Length of Stay	138.9	129.4

Exit to permanent housing

Figures 28 to 32 show differences by demographic subgroup, with significant differences across all demographic variables in both outcomes. Among those in recuperative care/stabilization housing, Non-Hispanic/Non-Latinos were more likely to exit to PH than Hispanic/Latinos.

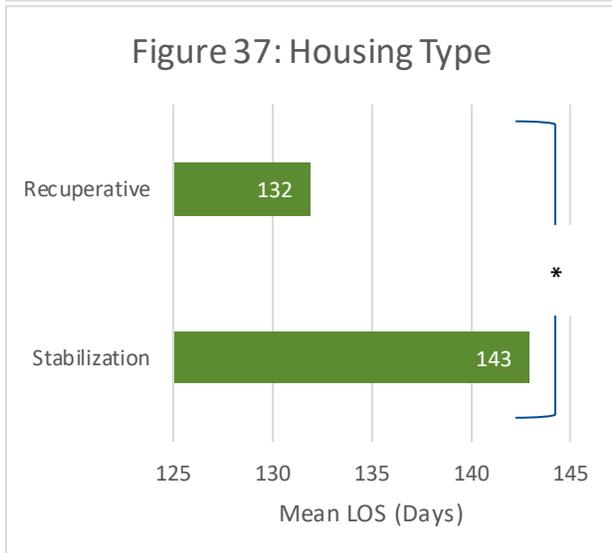
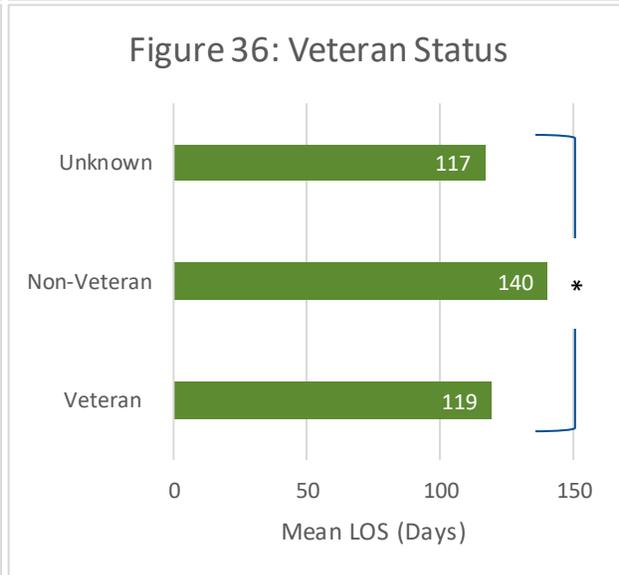
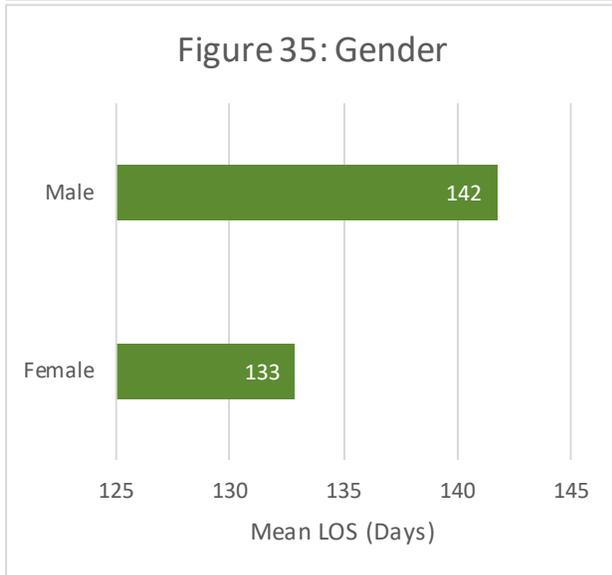
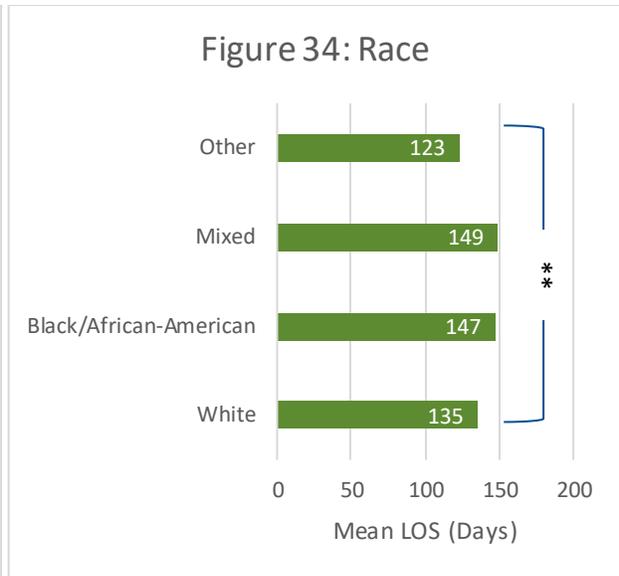
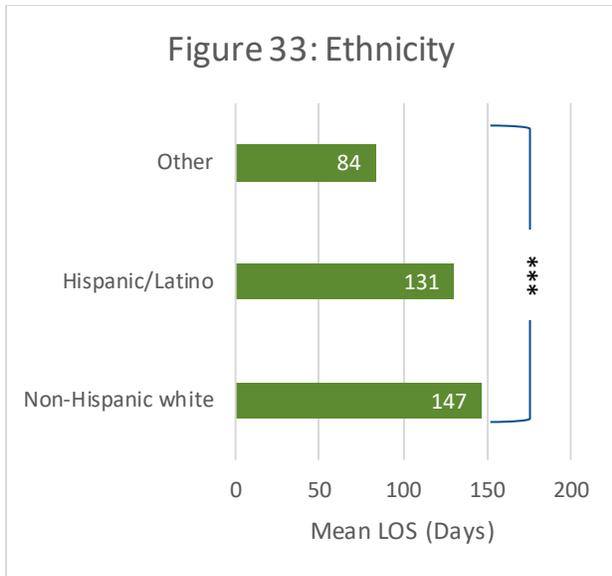




This differs from the HMIS population, for which no significant difference in ethnicity was observed. Like the HMIS population, whites were the least likely to exit to PH (23% compared to 27% of Black/African-Americans and 29% of mixed race). Females were also more likely to exit to PH than males (26% versus 23%) as was found in the HMIS population, although CHAMP data does not track transgender/nonconforming status. Those in stabilization housing were more likely to exit to PH than those in recuperative care (25% versus 21%).

Length of Stay

LOS differed across all demographic groups as well. Non-Hispanic/Whites had a longer LOS (146 days) compared to Hispanic/Latinos (131 days). Those with mixed race and African-Americans had longer LOS than Whites (149, 147, and 135 days, respectively). This also mirrors the HMIS population data. Males and non-veterans had longer LOS compared to their counterparts, and those in stabilization housing had longer LOS than those in recuperative care.



Summary for CHAMP sample

Similar differences across demographic subgroups were seen among those in stabilization housing/recuperative care compared to the HMIS emergency and transitional shelter population, although patterns across the two outcome variables differs. Unfortunately, we are not able to assess other subgroup comparisons in the CHAMP data.

Best practices and processes in need of improvement

Since Measure H has been implemented, several successes and potential best practices have emerged from the available data and performance evaluation results. Key informants pointed to the overall increase in interim beds as a significant success, as well as increased outreach and strong referral processes resulting in increased access to shelters. County hospital key informants described the referral process to DHS beds as very smooth and were able to easily communicate with Housing-For-Health staff in the event of any issues and resolve them quickly. Several “low barrier” strategies including 24-hour shelters, harm reduction policies for substance use disorder, accommodations for pets, and storage for belongings can be considered best practices for increasing access and are strong examples of shelters using Measure H funds to reimagine service delivery to meet clients where they are. Increased funding has also allowed shelters to hire more clinical staff, provide a much more expanded portfolio of services to clients and co-locate services such as health care to increase access. Funding has also enabled more opportunities for professional development such as trainings for staff in working with challenging populations. County key informants indicated fewer client complaints since the implementation of Measure H.

As noted previously, Measure H has been a driver of unprecedented collaboration across the county. Informants most frequently mentioned the establishment of universal shelter standards as a key milestone exemplifying this collaboration. Shelter key informants characterized the level of collaboration and communication with County agencies as very strong and expressed that they felt supported by DHS and LAHSA.

While several successes and identified best practices point to a generally positive trajectory for Measure H, key informants also identified several challenges. Lack of care continuity across the continuum of housing resources came up as a challenge frequently, and several key informants expressed the importance of maintaining relationships with clients as they transition through levels of housing to maintain progress. Shelter staff stated that some clients have been referred to shelter without an identified Intensive Case Management Services (ICMS) worker but needed access to services that they could not connect with through any other avenue. High rates of staff turnover were also cited as a key challenge with maintaining care continuity and could stymie clients’ progress towards housing readiness.

When considering the unique needs of subpopulations experiencing homelessness, key informants discussed a need for more nuanced consideration of the challenges certain clients might face when transitioning to permanent housing, such as clients with chronic conditions who must maintain access to certain services to maintain their housing.

For clients exiting hospitals, while public hospitals relayed extremely positive experiences with the referral process to DHS recuperative care beds, private hospitals indicated a lack of awareness of and difficulty with referring their patients to those beds. Because private hospital staff do not have access to HMIS, key informants expressed frustration with trying to verify where patients were in the CES process and connecting them with CES resources. Key informants also identified a lack of skilled care as a top issue, specifically a dearth of skilled care settings willing to accept Housing-For-Health clients due to their young age, co-occurring behavioral health issues, and lack of funding.

Key informants also identified several challenges with data systems, particularly the challenges of working with different data systems. Not only do different data systems seem to place a burden on providers to enter data multiple times (which also increases errors), the lack of communication between HMIS and CHAMP seems to create difficulties with getting a complete story for each client. Key informants also stated that data from other departments such as DMH and SAPC is not easily accessible.

Definition of program effectiveness

Definitions of program effectiveness vary depending on role, type of involvement in the program, and consideration of individual-level, program-level, and/or system-level assessment. However, the majority of key informants recognize that the ultimate goal of interim housing is to move individuals to permanent housing. Many key informants look to data related to performance metrics reported and published quarterly such as time from entry to permanent placement, type of exit (negative versus positive), time from referral to placement, and vacancy rate as indicators of success. Individuals also recognize the importance of looking historically at data to see improvements – even small and gradual improvements are important over time.

Maintaining individuals in interim housing as long as needed until permanent housing is available is also a key indicator of success; however, LOS as a measure of effectiveness on its own may be incomplete. Longer LOS may be viewed as a negative indicator, in that this indicates more time in a non-permanent versus permanent housing situation, as well as indicating less capacity to move unhoused individuals off the street. However, longer length of stay can also be a positive indicator in that individuals remain housed rather than exiting back to homelessness. Most key informants felt that the approved length of stay, particularly for recuperative care and stabilization housing, should be lengthened.

Many key informants note that qualitative data, in addition to the numbers/quantitative data, helps them

assess program effectiveness. For example, some individuals noted that reviewing client incident reports has shown a decrease in serious shelter incidents, which is an important outcome. Both agency and shelter provider staff also examine qualitative data in individual case notes to identify individual-level and program-level issues that need to be addressed.

ASSESSING PROGRAM EFFECTIVENESS: “We started monitoring evening activity, seeing an increase in incident reports at night and on the weekends. We learned there is not a lot for people to do at night. We didn't have case managers, so now we have staggered schedules of programs and case managers, we created social programming for the evening, and we have seen a decreased in the number of incidents.”

At the individual level, key informants consider many factors when assessing program effectiveness – Were physical health problems addressed? Was substance use reduced? Did clients increase interpersonal relationships while in shelter? Did clients become more self-sufficient? Did they learn life skills that will assist them in maintaining permanent housing? Were clients satisfied with services? Individual success stories are considered important indicators by many and are included in the quarterly reports.

At the program level, all agency and shelter staff report reviewing data on at least a weekly basis (for some measures such as bed rates they review daily) and utilizing data to identify problems and make program improvements. One key data-informed program improvement was time from referral to placement. DHS noticed that agencies were taking a long time to vet individuals. Once identified as a problem, they changed protocols to the process for receipt of referral, response, time to placement, and expectations of providers to accept clients. As a result, the referral-placement timeframe was reduced from two weeks to three days.

Funding Sources, Restrictions, and Administration: Effects on Service Provision in Practice

County agencies have multiple funding sources to support B7 and E8 beds, with different types of restrictions imposed from each source. DHS funding for recuperative care/stabilization housing comes from a variety of sources, including Measure H, state funds, their standard operating budget, the Office of Diversion and Reentry, as well as additional funding sources that pre-dated Measure H. Medi-Cal funds through Health Homes and Whole Person Care are also utilized to various extents by County agencies and shelter providers.

LAHSA derives significant funds from Measures H for shelter services, with additional funds from the city, other County sources, state funding, and DPSS funding. LAHSA is able to use Measure H funding to drive programming for the rest of the funding sources. According to one LAHSA staff, the city is willing to align their dollars with Measure H, making the contract and service provision process more streamlined.

Among shelter providers interviewed, many serve various subpopulations and provide both B7 and E8 services and services through other funding sources. For example, some providers have funds from the Office of Diversion and Reentry (through AB109 funds) to support those exiting jails. Others receive city funding as well as funding directly from health plans and private hospitals.

Overall informants noted significant challenges involved with different funding sources in terms of eligibility requirements, certification requirements for staff, performance targets and reporting requirements, and bed rates. Several respondents noted challenges in funding provided by family-serving agencies such as DPSS, which tends to have the most restrictions. One respondent noted key barriers with DPSS funding, which has a much lower bed rate than DHS, stringent eligibility criteria that is challenging for most clients, and unfunded mandates for service provision.

Measure H funds are much less restrictive than other funding sources, particularly funding from the city, DPSS, and HUD. The limitations on LOS and very specific eligibility criteria for some funding sources makes it challenging to provide consistent and quality care to all clients. One shelter respondent noted that working with DHS funds through B7 is much more flexible than hospital funding in terms of LOS. Hospitals often pay for only 7 days, while DHS allows a much longer LOS through Measure H funds.

While acknowledging the challenges incurred with multiple funding sources, shelters provide the same level of services for all clients. Respondents described complicated funding policies at the administrative level to ensure consistent services, including utilizing more restrictive funding first, so those dollars are used as efficiently as possible, allowing more leeway with less restrictive sources (e.g., E8 funds) for use

Despite restrictions on DPSS funds, LAHSA fully utilizes those funds by leveraging Measure H funds to ensure they meet DPSS requirements.

with those not meeting the restrictive eligibility criteria.

Tracking various funding sources is handled at the administrative level, with complex record-keeping and financial tracking. Shelter

respondents noted that billing also differs across funding sources, which is difficult for the finance unit to maintain.

All respondents endorse streamlined funding sources as the ideal given the complexity of different funding restrictions, bed rates, and standards they currently manage. However, many respondents also recognize that the extent of the homelessness problem requires multiple strategies and funding sources to be able to serve all clients in need.

Recommendations

Based on our evaluation, we have identified a set of recommendations for enhancing the ongoing work for Strategies B7 and E8. These recommendations are based on input from key informants as well as HMA's assessment of key areas of focus.

Services

Key informants interviewed for this evaluation suggested enhancing service provision in multiple areas. However, given funding limitations of Measure H, any increase in services in one strategy or service area would likely result in a decrease in funding for other strategies/services. Given the centrality of the interim housing shelter strategies to the County's overall coordinated approach to homelessness – a degree of importance that is further amplified by current permanent housing shortages the County should seek to identify or generate additional resources for key services to be made available through or in coordination with interim housing providers, including the following:

- Employment services can be provided at shelter sites, with a focus on employment opportunities that offer a living wage and increase self-sufficiency. Providing incentives for employment services providers could increase their commitment to working with the homeless population.

- Community-based clinical and physical health services can be made available to better meet the needs of high acuity persons in the interim housing system. This is particularly for clients in need of SUD treatment services, which are lacking at shelter sites.
- For TAY, provide additional counseling and family therapy that is appropriate for this age group. Additionally, consideration should be made to increase the number of TAY-specific shelter sites/beds and increase funding for TAY drop-in centers.
- Identify ways to access and pay for licensed nursing home facilities. This may require focused effort to build relationships with these facilities, particularly by DHS. Funding could be allocated at the state/Medicaid level.
- Engage health plans to support services provided in the shelter/recuperative care setting. Many health plans recognize the need to address social determinants of health. The timing may be right to approach plans with specific requests for assisting the homeless population.
- Increase the allowable LOS at shelters, especially for high-acuity clients. Measure H has resulted in increased services for those exiting institutions, and this has increased the number of complex, high-acuity clients entering the interim shelter system. While increased LOS may cause more bottlenecks in moving individuals from the street to shelters, this will ensure that individuals in shelters exiting to permanent housing have a great chance of success.
- Assess the need for case management on a case-by-case basis. Many individuals may not need intensive services, and for those who do not, they may be moved through the shelter system to permanent housing more quickly.
- More services that are culturally and linguistically appropriate are needed to address the specific needs of various subpopulations, particularly for the Asian/Pacific Islander (API) population. Los Angeles County has the highest API population outside of Asia, and there are already existing services across the county that could be brought directly to the shelter sites. This also includes translating the VI-SPDAT into API languages.
- Building on the momentum of universal shelter standards, establish and enforce specific recuperative care quality standards, aligned with NHCHC standards or another identified evidence-based standard.
- The DV population is significant – 30% of those in HMIS have experienced DV upon entry to the shelter system. Prioritize the DV population and examine ways that service delivery might need to be reimaged for this population. Diversion as an initial focus is not appropriate for this population, so time spent on this is an inefficient use of resources.
- Replicate the development of additional “Safe Landing” full-service interim housing projects.
- Explore the utilization of host homes, apartment share, shared housing, sober living, and board and care facilities. Explore the homeless services skilled-nursing facility model.

Staffing

- While shelter providers have successfully scaled up since Measure H was implemented, it is important to ensure they have the support and resources needed to continue to grow and expand.
- Target funding to provide intake, counseling, and case management staff during the evening hours and hire problem-solving specialists.

- Assess salary rates for staff based on experience needed to work with acute populations. If funding is not available to hire more experienced staff, alternative staffing models, such as regional professionals who rotate sites should be explored.
- At a minimum, all staff, regardless of experience level, should receive training on working with a population with complex needs. This could be accomplished through developing a staffing ‘boot camp’ that is available to all new staff. The Learning Communities can also serve as a means for enhancing staff training. Funding set aside specifically for staff training could support this effort.
- Address shelter staff burnout, recognizing that this is a highly stressful job that requires greater focus on staff self-care.

Referral/Intake Process

- Develop a process that will allow real-time assessment of all open beds, particularly in emergency shelters. Streamline communication between interim housing and emergency shelters so that immediate and direct referral to emergency housing can be made in the event individuals show up to interim housing sites without bed availability.
- Examine strategies to increase the accuracy of initial assessments. This may include re-examining the assessment instrument. Often clients may not adequately comprehend the questions in the CES intake survey, resulting in inaccurate scoring. Provide additional training to CES and other intake staff on interfacing with clients to determine acuity levels during the intake process.
- Identify ways to reduce paperwork required at intake. The CES intake process is lengthy and can result in delays and bottlenecks. Examine data to determine wait times from initial referral to a CES intake and actual intake. Identify ways to reduce the wait time.
- Identify strategies to reduce the lag time between referral to ICMS provider and initial contact. Flexible hours for ICMS staff may enhance the ability to meet clients where they are within a short period of time. Ensure that ICMS staff come to where clients are located, and this protocol is consistently followed.
- The referral process from private hospitals to both DHS and the CES should be strengthened. Provision of CES staff on site at hospitals (potentially funded by the hospitals themselves) can make the referral process faster and more efficient.
- Proactively engage private hospitals to provide informational resources on both DHS and LAHSA-funded shelter as well as private recuperative care options. The Hospital Association of Southern California is a key partner in engaging with private hospitals.

Continuity of Care

- Develop protocols to allow the same case manager to work with clients throughout the continuum—from interim to permanent housing—to support clients for at least a 3-month period after placement in permanent housing. This will alleviate the need for permanent housing staff to devote time to developing trust with clients and increase the likelihood of successful stays in permanent housing. This could be accomplished through interdisciplinary teams, similar to what occurs in Strategy E6.
- Services to support the transition to permanent housing should include training on how to budget, how to be a successful employee, and links to supportive services once in permanent housing.

Collaboration

- Enhance collaboration with and participation by SAPC. Other departments are working very collaboratively, but service provision could be improved with more intensive involvement of SAPC staff, both at the leadership level and the shelter provider level.
- Continued collaboration among all stakeholders is needed to address the ongoing political pressure and negative press about the homelessness issue in Los Angeles.
- Build on the successful collaborative effort to develop shelter standards to move toward more consistent standards across departments in other areas, including contract requirements, performance metrics, and reporting requirements, particularly across DHS, LAHSA, and DMH. Continue to explore other areas to streamline forms and processes required by various agencies.

Data

- Utilize existing data to model the entire homelessness continuum and develop accurate targets. This will assist in determining funding needs and priorities.
- Develop more realistic outcomes for performance metrics. Expectations for movement to permanent housing may be too high, given the lack of housing availability, as well as the need for greater LOS in interim housing to ensure the successful transition.
- Explore options for better data integration that is automated, or possibly utilization of one system across agencies.
- It would be beneficial to track and report, at a minimum, referral for mental health and substance use services, and if possible, services actually received. These data could provide insight into what additional services may be needed for homeless individuals identified with these problems.

Bed Rates

- Explore ways to increase bed rates above the current rates for both interim beds and recuperative care/stabilization housing beds. The higher rates will allow for additional services, more experienced staff, and can ultimately shorten the LOS with more intensive services in a shorter period of time.

Funding Sources

- Identify ways to streamline the processes and requirements of multiple funding sources. For example, new state money allows alignment with Measure H, and this funding source can be administered with requirements that are consistent with LAHSA.
- Engage in advocacy around identifying sustainable funding sources. Engage with health plans, Medicaid, and Medicare for reimbursable services provided.

Conclusion

Measure H has had a significant positive impact on interim housing shelter services and bed availability. Cross-agency collaboration has ensured that appropriation of Measure H dollars and implementation of programs has been done through a purposeful and transparent process. This has included intensive efforts to coordinate with and support shelter providers to ensure the appropriate placement of

individuals within interim housing, as well as movement to permanent housing. Standards of care have been implemented, best practices are being shared, provider training has increased, and serious incidents have been reduced. Given the severe limitations in available permanent housing, a focus for future efforts can include improving efficiencies in the intake and referral process generally, and for hospitals specifically, as well as increased ability to identify housing availability in real time. Although certain challenges remain, the momentum of Measure H is making a difference in the lives of homeless individuals and families in Los Angeles County.

Appendices

Appendix A. Los Angeles County Strategies to Combat Homelessness

Los Angeles County Strategies to Combat Homelessness

E. CREATE A COORDINATED SYSTEM		
E1 Advocate with Relevant Federal and State Agencies to Streamline Applicable Administrative Processes for SSI and Veterans Benefits	E5 Decriminalization Policy	E12 Enhanced Data Sharing and Tracking
E2 Drug Medi-Cal Organized Delivery System for Substance Use Disorder Treatment Services	E6 Countywide Outreach System	E13 Coordination of Funding for Supportive Housing
E3 Creating Partnerships for Effective Access and Utilization of ACA Services by Persons Experiencing Homelessness	E7 Strengthen the Coordinated Entry System	E14 Enhanced Services for Transition Age Youth
E4 First Responders Training	E8 Enhance the Emergency Shelter System	E15 Homeless Voter Registration and Access to Vital Records
	E9 Discharge Data Tracking System	E16 Affordable Care Act Opportunities
	E10 Regional Coordination of Los Angeles County Housing Authorities	E17 Regional Homelessness Advisory Council and Implementation Coordination
	E11 County Specialist Support Team	

B. SUBSIDIZE HOUSING	A. PREVENT HOMELESSNESS	C. INCREASE INCOME
B1 Provide Subsidized Housing to Homeless Disabled Individuals Pursuing SSI	A1 Homeless Prevention Program for Families	C1 Enhance the CalWORKs Subsidized Employment Program for Homeless Families
B2 Expand Interim Assistance Reimbursement to additional County Departments and LAHSA	A2 Discharge Planning Guidelines	C2 Increase Employment for Homeless Adults by Supporting Social Enterprise
B3 Partner with Cities to Expand Rapid Re-Housing	A3 Housing Authority Family Reunification Program	C3 Expand Targeted Recruitment and Hiring Process to Homeless/Recently Homeless People to Increase Access to County Jobs
B4 Facilitate Utilization of Federal Housing Subsidies	A4 Discharges From Foster Care and Juvenile Probation	C4 Establish a Countywide SSI Advocacy Program for People Experiencing Homeless or At Risk of Homelessness
B5 Expand General Relief Housing Subsidies		C5 Establish a Countywide Veterans Benefits Advocacy Program for Veterans Experiencing Homelessness or At Risk of Homelessness
B6 Family Reunification Housing Subsidy		C6 Targeted SSI Advocacy for Inmates
B7 Interim/Bridge Housing for those Exiting Institutions		
B8 Housing Choice Vouchers for Permanent Supportive Housing		

D. PROVIDE CASE MANAGEMENT AND SERVICES		
D1 Model Employment Retention Support Program		
D2 Expand Jail In Reach		
D3 Supportive Services Standards for Subsidized Housing		
D4 Regional Integrated Re-entry Networks - Homeless Focus		
D5 Support for Homeless Case Managers		
D6 Criminal Record Clearing Project		

F. INCREASE AFFORDABLE/HOMELESS HOUSING		
F1 Promote Regional SB 2 Compliance and Implementation	F3 Support Inclusionary Zoning for Affordable Housing Rental Units	F5 Incentive Zoning/Value Capture Strategies
F2 Linkage Fee Nexus Study	F4 Development of Second Dwelling Units Pilot Program	F6 Using Public Land for Homeless Housing

priorities.lacounty.gov/homeless

Appendix B: Key Stakeholder Interviews

Date	Interviewee	Title	Agency
7/29/2019	Max Stevens	Principal Analyst	LA County CEO
7/30/2019	Michael Castillo	Senior Analyst	LA County CEO
7/30/2019	Elizabeth Ben-Ishai	Principal Analyst	LA County CEO
8/1/2019	Ashlee Oh	Principal Analyst	LA County CEO
8/1/2019	Libby Boyce	Program Implementation Manager	DHS Housing for Health
	Juataun Mark	Director of Interim Housing	
8/1/2019	Justin Dae	Real Estate Acquisitions Manager	Brilliant Corners
8/1/2019	Vicki Nagata	Director of Access, Referrals, and Engagement	DHS Housing for Health
8/1/2019	Wade Trimmer	Executive Director of Housing and Homeless Services	National Health Foundation
8/7/2019	Raquel Zeigler	Crisis Housing Coordinator	LAHSA
	Sofia Peralta	Crisis Housing Coordinator	
8/12/2019	Andrew Hill	Interim Housing Placement Coordinator	LAHSA
8/12/2019	Whitney Lawrence	Director of Policy and Planning	DHS Housing for Health
8/12/2019	Tonja Boykin	Chief Operating Officer	Weingart Foundation
8/13/2019	Kelsey Madigan	Director of Interim Housing For Individuals	LA Family Housing
8/22/2019	Elizabeth Saldana	SVP of Operations	Illumination Foundation
	Christina Martinez	Director of Medical Care Coordination	
	Cindy Villasenor	Associate Manager of Case Management	
8/22/2019	Awade Khan-Variba	Program Manager	PATH Hollywood
	Stephen Feichter	Senior Director, Metro LA Programs	
8/23/2019	Tiffany Shirley	Director of Family Services	PATH W Washington
	Elizabeth Jimenez	Associate Director of Family Programs	

8/28/2019	Christina Barajan	Contract and Compliance Manager	First to Serve Vernon
	Michelle Bush	Director of Programs	
	Rene Ohta	Program Manager	
	Wendy Gaston	Clinical Director	
9/5/2019	Lise Ruiz	Program Manager	DMH
9/25/2019	Charmaine Dorsey	Director Of Patient And Social Support Services	DHS
9/19/2019	Veronica Turner	Clinical Social Worker Supervisor II	Harbor UCLA
10/1/2019	Jeff Proctor	Manager of System Components, Acting Associate Director of Performance Management	LAHSA
10/2/2019	Julie Pan	Senior Clinical Social Worker	LAC USC
10/22/2019	Maria Barahona	Compliance Director	Haven Hills
10/22/2019	Jorge Reyno	VP, Population Health	MLK Hospital
10/22/2019	Patima Kolomat	Shelter Program Director	Center For The Pacific Asian Family
10/23/2019	Marcia Penido	Director of Care Coordination	Huntington Memorial Hospital
	Laura Raya	Community Coordinator	
	Heather Heilmann	Manager of Health Navigation	
11/6/19	Kris Nameth	Associate Director of Programs	Los Angeles LGBT Center

Appendix C. Interview Guides

Evaluating the Effectiveness of Los Angeles County's Homelessness Strategies – Interim and Emergency Housing Interview Guide – County Staff

Thank you for participating in this interview. The purpose of the interview is to find out more about your perspective on the County's Homelessness Strategies for Strategy B7 and E8 – Emergency and Interim Housing. The interview will last about one hour, and we will be asking your thoughts on a variety of questions, including how effective are program activities in which you are involved in meeting the overall goals of the County's strategies, program best practices, challenges, and areas for improvement.

Your responses will be kept confidential. We will not use your name in any reports. We will be taking detailed notes, as well as recording the interview. We may include quotes in our report, but these won't be attributed to any individual. The report will be a summary of themes across multiple interviews we are conducting with County staff and providers of housing and shelter services.

Do you have any questions before we begin?

[Interviewer state individual's name, agency, date, and if known, position title]

General

1. What is your position title?
2. What is your role within the agency for the interim/emergency shelter homelessness program(s) in LA County? How long have you been in this position?

Program Services and Implementation

3. Please describe the services addressing homelessness provided through your department's programming in which you are involved.
4. What are the funding sources for the services?
 - a. (If H and other funding sources) Do you see differences among these funding sources in how they support services addressing homelessness? If yes, please describe. What are the challenges in having multiple funding sources? Would the program benefit from more streamlined funding? How?

- b. Are there restrictions on what services can be provided with the current funding sources? Do these restrictions impact how effectively the program is run? If yes, how?
5. What do you see as the strengths of the program as it is currently being implemented?
6. What are some of the challenges in implementing the program?
7. What are some areas for improving program functioning?
8. What are the key differences between the services provided by DHS, LAHSA, DMH and DPH-SAPC?
9. What do you see as the most difficult challenge(s) in individuals experiencing homelessness making the transition from interim/temporary shelter to permanent housing? What suggestions would you have for how your agency can support improvements to this process?

Program Data Tracking and Performance Measurement

10. Can you describe how program activities and outcomes are tracked? How are data tracked and entered? What are some of the challenges with this/these data systems? If multiple data systems – how are these systems integrated? Do DHS, LAHSA, DMH, and DPH/SAPC share data to establish, track and respond to outcomes for the system of programs addressing homelessness in LA County? Do you have suggestions about how this can best be accomplished?
11. How do you define program effectiveness? What tells you how well the program is working?
 - a. Have you used data to make programmatic changes? Can you provide some examples?

Collaboration

12. Can you describe how the various agencies/departments – DHS, LAHSA, DMH, and DPH/SAPC – collaborate in the implementation of their programs and services addressing homelessness? Are there formalized structures in place that support interagency collaboration? Do you have suggestions for how collaboration could be further developed to improve efficiencies in use of funds and improve outcomes from programs funded?
13. How are strategies B7 and E8 integrated with other strategies currently being implemented? Where are there opportunities for improved integration and efficiencies?
14. Do you feel the annual budget allocation process is appropriate? Would you make any adjustments to the process? Do you feel the current allocation is fair?
15. How does your agency/department collaborate/coordinate with hospitals and the criminal justice system/jails in working with the homeless population? How can coordination be improved?

Final Question

16. Can you identify one or two things in the County that are working well and one or two things that are not working well to effectively and efficiently provide interim/shelter services for homeless individuals and families?

Evaluating the Effectiveness of Los Angeles County’s Homelessness Strategies – Interim and Emergency Housing Interview Guide – Shelter Staff

Thank you for participating in this interview. The purpose of the interview is to find out more about your perspective on the County’s Homelessness Strategies for Strategy B7 and E8 – Interim and Emergency Housing. The interview will last about one hour, and we will be asking your thoughts on a variety of questions, including how effective are program activities in which you are involved in meeting the overall goals of the County’s strategies, program best practices, challenges, and areas for improvement.

Your responses will be kept confidential. We will not use your name in any reports. We will be taking detailed notes, as well as recording the interview. We may include quotes in our report, but these won’t be attributed to any individual. The report will be a summary of themes across multiple interviews we are conducting with County staff and providers of housing and shelter services.

Do you have any questions before we begin?

[Interviewer state individual’s name, agency, date, and if known, position title]

General

1. What is your position title?
2. What is your role within this organization? How long have you been in this position?
3. Does your organization provide interim/bridge housing, or emergency shelter, or both?
4. Do you provide recuperative care?
5. Do you contract with DHS, LAHSA, or both? Any others?
6. How long has your organization been contracting with the County to provide interim/bridge housing?

Program Services and Implementation

7. Please describe the services addressing homelessness provided through your organization. What population(s) do you serve? Do you have any special focus on or special programs for specific populations? Please tell me about your agency’s reasons for and approach to serving this/these specific population(s).
 - a. Do you think the services you provide to address the needs of your population are sufficient? What additional services would your population benefit from?

- Have you looked into starting to provide any additional services? What would be needed for you to do this?
8. Please describe your process for (1) receiving and accepting or denying referrals; and (2) your process for enrolling new clients.
 - a. Do you have any recommendations for how the referral process could be improved?
 9. What are the funding sources you receive?
 - a. (If H and other funding sources) Do you see differences among these funding sources in how they support services addressing homelessness? If yes, please describe. What are the challenges in having multiple funding sources? Would the program benefit from more streamlined funding? How?
 - b. Are there restrictions on what services can be provided with the current funding sources? Do these restrictions impact how effectively the program is run? If yes, how?
 - c. If you provide recuperative care, how is that funded?
 10. What is the bed rate you receive through the various funding sources?
 - a. Is this funding sufficient? What would be an optimal bed rate?
 11. What do you see as the strengths of your program as it is currently being implemented?
 12. What are some of the challenges in implementing your program?
 13. What are some areas for improving program functioning?
 14. What do you see as the most difficult challenge(s) in individuals experiencing homelessness making the transition from interim/temporary shelter to permanent housing? What suggestions would you have for how your agency can support improvements to this process?

Program Data Tracking and Performance Measurement

15. Can you describe how program activities and outcomes are tracked? How are data tracked and entered? What are some of the challenges with this/these data systems? Do you submit data through CHAMP, HMIS, or both systems? If both, what are some suggestions for streamlining the data collection process?
16. How do you define program effectiveness? What tells you how well your program is working? How often do you review your data?
 - a. Do you follow a process for implementing improvements because of regular program performance data review? Have you used data to make programmatic changes? Can you provide some examples?

Collaboration

17. Can you describe how your organization collaborates with DHS/LAHSa? What suggestions do you have for improving communication and collaboration with these agencies?

Final Question

18. Thinking about the Measure H strategies and activities overall, can you identify one or two things in the County that are working well and one or two things that are not working well to effectively and efficiently provide interim/shelter services for individuals and families experiencing homelessness?

Evaluating the Effectiveness of Los Angeles County’s Homelessness Strategies – Interim and Emergency Housing Interview Guide – Hospital Staff

Thank you for participating in this interview. The purpose of the interview is to find out more about your perspective on the County’s Homelessness Strategies for Strategy B7 –Interim and Emergency Housing - as it relates to the release of homeless patients from institutional settings, including hospitals. The interview will last about one hour, and we will be asking your thoughts on a variety of questions, including the effectiveness of the referral and release process, best practices, challenges, and areas for improvement.

Your responses will be kept confidential. We will not use your name in any reports. We will be taking detailed notes, as well as recording the interview. We may include quotes in our report, but these won’t be attributed to any individual. The report will be a summary of themes across multiple interviews we are conducting with County staff and providers of housing and shelter services.

Do you have any questions before we begin?

[Interviewer state individual’s name, agency, date, and if known, position title]

General

1. What is your position title?
2. What is your role within this organization? How long have you been in this position?
3. What is your role in activities related to referral and release of homeless individuals from the hospital setting?

Referral Process

4. Please describe how you identify homeless patients receiving care in your hospital.
 - a. Does this differ for ER patients who are not admitted and admitted patients?
5. Does the hospital have dedicated funding to a staff position for identifying and referring homeless patients upon release?
6. Please describe the process for referring patients who are homeless to appropriate care settings.
 - a. How many providers do you work with? How have you identified these providers?
 - b. Have you seen an increase in the number of private recuperative care providers since Measure H was implemented?

- c. Are you familiar with the referral process for DHS housing?
 - d. Do you have contractual arrangements with recuperative care providers? With DHS? With private providers?
- 7. How do you determine level of need/acuity level for those being released in terms of whether they will need recuperative care housing versus regular housing?
- 8. What happens when you cannot find appropriate housing for individuals upon release?
 - a. Can you describe any instances when patients have remained in the hospital longer than necessary due to unavailability of housing? How often does this happen?
- 9. Have you seen a reduction in inappropriate stay length since Measure H has been implemented in 2016?
- 10. Do you track where homeless individuals have been released in your electronic health records?
- 11. Have you seen a reduction in returns to the ER/hospital since Measure H has been implemented? Do you regularly track and report this?
- 12. What are the challenges in identifying appropriate housing?
- 13. What are the challenges with the referral process?
 - a. Do you have any recommendations for how the referral process could be improved?
- 14. What additional resources would be helpful in assisting you in identifying and referring homeless patients to appropriate housing upon release?

Appendix D. Detailed Sample Selection Criteria for HMIS and CHAMP Data

Steps in Data Selection Process for HMIS

1. Merge the following data files, matched by PersonalID
 - a. Project_Out
 - b. Enrollment_Out
 - c. Exit
 - d. Disabilities_Out
 - e. Health-and-DV_Out
2. Select sample based on parameters outlined below

Sample Selection for HMIS

1. 'ProjectType' = 1 – Emergency Shelter or 2 – Transitional Housing
2. Entry date on or after July 1, 2017
3. Exclude if only associated with a Winter Shelter (winter shelters identified by name)
4. Individual identified as a Head of Household – 'Relationship to HofH' = 1
5. Exit data valid/non-missing – 'ExitDate' has valid response and occurs prior to August 15, 2019 (date of data pull)

Final sample size = 20,574 unique individual records

Sample Selection for CHAMP

Based on a conversation with Kevin Flaherty from DHS, we de-duplicated the data file based on the following decision rules:

1. For duplicate records with identical data EXCEPT for number days homeless –select the record with the larger number days homeless.
2. For duplicate records with the same check-in date but different check-out date, select the record with the longest length of stay and assume the record with the earlier exit date is incorrect.

Sample selection criteria include:

1. Entry date on or after July 1, 2017.
2. Exit data valid/nonmissing – 'Interim_Housing_Exit_Date' has valid response

Final sample size = 3, 489 unique individual records